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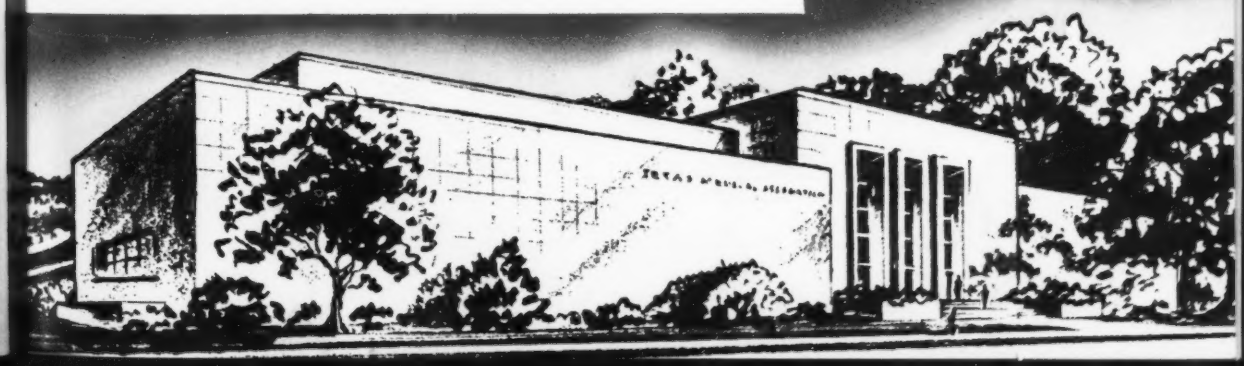

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President's Page

MEDICAL STUDENTS' DAYS

Feeling that a closer liaison should exist between the medical students—the doctors of tomorrow—and organized medicine, the Texas Medical Association instituted a series of "Medical Students' Day" programs in the fall of 1953 in cooperation with the Dallas, Harris, and Galveston County Medical Societies. The speakers have been key officers of the Texas Medical Association and key members of our central office staff.

These talks have been indoctrinational in character, geared to answer the questions in the minds of the soon-to-be MD's. They have covered the organizational setup at the county, state, and national levels with a complete dissertation on the services offered at each level. Detailed information has been given on the business side of medicine with particular stress on the physical setup of a doctor's office, including office records, office help, bookkeeping, and billing, Excellent information has been presented on the ethics involved in the practice of medicine with our Code of Ethics as given by the American Medical Association as well as the Hippocratic Oath being discussed thoroughly.

The medicolegal problems involved in our present day practice have been presented with great clarity. This has been one of the best received topics, probably because it is realized that it is becoming more important all the time since the number of malpractice suits filed has been increasing so rapidly and because it is a subject about which little is known by the average medical student. Also, the question of the doctor as an individual and as a citizen has been discussed. An attempt has been made to show the place he should assume in community life, in civic, educational, and religious affairs.

It has been my pleasure and privilege to speak at all three of our Medical Students' Day programs this fall—at Southwestern, Baylor, and the University of Texas Medical Branch—and I can assure you

that I know of nothing which is being sponsored by the Texas Medical Association that is appreciated more fully than these programs.

At the two recent programs at Houston and Galveston unsigned comments were requested from the students in attendance. An analysis of scores of questionnaires returned revealed an amazingly unanimous favorable response. "Excellent program," "well planned," "very enjoyable and informative," "practical, informative, and enjoyable" were the remarks most often encountered. One said, "Instead of the short talks, lectures over a one to two day period in the form of a short course would be desirable along the topics covered." Another said, "I believe the most valuable addition would be that of more time. We spend 304 hours on anatomy and only 5 hours on problems of medical practice."

I may be speaking out of turn, but a proposal at a recent meeting of the Committee on Public Relations impressed me so favorably that I am going to risk censure in order to let you hear of it too. The committee was so enthusiastic over the exceptionally fine response obtained from the Medical Students' Days that the members thought the Texas Medical Association could present a similar program as a service to interns and residents at the annual session in Galveston to run concurrently with the refresher courses on Monday, Tuesday, and Wednesday, April 23-25. This proposal is being presented to the Council on Scientific Work as this Journal goes to press. If it meets with approval, it will then be presented to the Board of Trustees and to the Executive Council.

Thus, if this plan is approved, another step forward will have been taken in rendering service to the fledgling doctor of medicine and at the same time in helping him to realize that the older physician is interested in his success and welfare, thereby increasing the chances that he will assume his rightful place in organized medicine.

J. Layton Cochran

HOSPITALS–INSURANCE–PHYSICIANS

In 1952, the Hospitals-Insurance-Physicians Joint Advisory Committee tackled the tremendous task of promoting understanding and cooperation between hospitals, insurance companies, and physicians in an effort to promote the growth and effectiveness of the free system of voluntary health insurance coverage. Within the past three years, the participating associations of the committee have achieved almost 100 per cent success in resolving disputes and misunderstandings in insurance cases.

Encompassing a wide range of activities from the drafting and promotion of uniform claim forms to consulting and acting as intervenor between the professional parties in insurance matters, the committee is composed of representatives of the Texas Accident and Health Claims and Underwriters Association, Texas Association of Accident and Health Underwriters, Health and Accident Underwriters Conference, Private Clinics and Hospitals Association of Texas, Texas Hospital Association, and Texas Medical Association. Texas Medical Association representatives are Dr. Everett C. Fox of Dallas and Dr. Harvey Renger of Hallettsville.

The committee believes that its efforts should be concentrated on the cooperating professional groups. Since it is not within the power or purpose of the committee to receive and handle inquiries or complaints from the general public concerning hospital or medical insurance, the committee has specifically avoided any generalized publicity through newspapers or similar media.

From a practical standpoint, the greatest effectiveness of the committee has been to serve as a sounding board for hospitals, physicians, and insurance companies on those actions which impair the proper functioning of health insurance and to focus attention on points of friction which lead to misunderstandings and eventually to public disapproval.

Through discussion in open meetings, the problems which affect each group are brought to light. Alleviation of the sources of irritation between the three groups has promoted advancements in the area of better hospitalization and medical care insurance.

Through joint counsel, improper practices are scrutinized. Although the committee has no punitive powers, the fact that these improper practices are being observed tends to reduce the incidence of insurance abuses. The committee has experienced a high degree of success in resolving disputes and misunderstanding in insurance

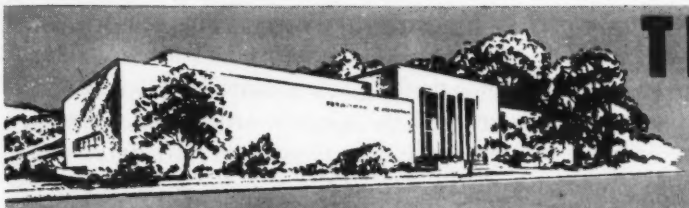
cases, although it must rely entirely upon the voluntary cooperation of the physician, hospital, or insurance company toward which an inquiry is directed.

Recently, the Hospitals-Insurance-Physicians Committee has decided to rotate its meetings among the principal cities in the state so as to increase the value of its functions to the component associations in the various cities and to give local medical, hospital, and insurance groups the opportunity of participating in its transactions.

Although the committee was officially established August 16, 1952, in Dallas, groundwork was begun two years before. During 1950 and 1951, the associations represented in the present committee developed a standardized hospitalization and physician's insurance report form. The success of this form, the first of which was drafted in June, 1951, and which in revised form has been adopted rather generally throughout the state, led to the formation of the permanent committee.

In addition to the development of the aforementioned report forms, the cooperative action of the committee has resulted in joint endorsement of a standard group hospitalization insurance report form, an exchange of speakers, and plans to assist the department of agricultural education at Texas Agricultural and Mechanical College in preparing a teaching plan for rural schools.

Functioning with little fanfare, the committee has been holding regular bimonthly meetings for the past three years. It has not sought to become, and intentionally has avoided becoming a numerically "big" organization. This policy has been followed deliberately because of the firm conviction that the objectives of the committee can be attained best through the close personal ties and identity of interests among the professional associations involved. The usefulness of the committee to the participating professional groups is limited only by the cooperation of the groups and utilization by them of the committee as a vehicle for continued improvement in voluntary health insurance to the public at large.



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Boost from Industry

The recent grant from the Ford Foundation of 290 million dollars to hospitals and medical schools is gratifying and encouraging to the medical profession. In Texas alone, 144 privately supported hospitals will be aided by grants ranging from $10,000 to $250,000 each, and Baylor University College of Medicine will receive a share of the 90 million dollars set aside for privately supported medical schools.

Higher education is expensive out of all proportion to the number who can be taught, and medical education is even more expensive. To achieve excellence in medicine with its modern day complexity requires time, talented teachers and expensive technical equipment, and any compromise with excellence in our profession would be disastrous.

Hospital costs are so great today that many ill persons cannot afford this necessary expense. These high costs are not due to profits, but to the increased cost of hospital construction and greatly increased operating expenses. Individual philanthropists capable of continuing adequate support of medical education and hospitals are fewer in number and are less able to contribute because of increasing income and inheritance taxes. This leaves the gap to be filled by small donations, through such efforts as the American Medical Education Foundation and other groups, business and industry, or the government. It is indeed preferable for this needed money to come from private sources.

Business long has recognized the need for supporting technical education to insure an adequate supply of highly skilled personnel for use in industry. This large donation to medical education and hospitals from the Ford Founda-

tion indicates a recognition of the importance to industry of good medicine and the necessity of good teaching centers and hospitals to insure the high caliber of medical care so singularly enjoyed by the vast majority of our people.

The quality and distribution of medical care is directly dependent on an adequate supply of medical students of high moral character and superior intelligence. This grant from one of industry's greats is especially timely as it coincides with a marked dropping off in the number of applicants for medical schools. Only by showing the intelligent and thinking college student that industry, business, the large philanthropist, and the small donor are willing to cooperate to keep him a free individual practitioner with the hope of adequate reward for his services can we compete with business and industry for his skills. The long years of training necessary to make a good doctor deter some of our best minds, but this is minor when compared to the realization that those years of work might lead to regimentation, to criticism within and without his profession, and to a feeling that personal reward is somehow undeserved.

Let us all thank the Ford Foundation, both for its great gift and for the help and encouragement to our profession it offers at this rather critical period in our thus far glorious history.

—ALBERT W. HARTMAN, M. D., San Antonio.

What's Your Opinion?

In this *Journal,* many changes have been made; some, such as the green on the cover and the "new look" of the first editorial page, you probably will notice immediately. Others, such as the larger type size used for tables and the different kinds of type used for headlines, may not be so obvious. In totality, the changes in spacing and typography are designed to give you a more readable and lively looking *Journal.*

In addition to a new face, the *Journal* has added a new feature—a signed editorial written by a physician and printed on the first editorial page. It is thought that physicians often are in a position to make pertinent contributions to the *Journal* through editorials, as well as through the Current Editorial Comments column and the scientific articles for which they long have been responsible. All contributions will be welcomed, and will be considered for publication with the usual editorial rights to submit the paper to experts for review, to accept or reject, and to edit.

Because the *Journal* is published for the doctors of Texas, your opinions are of paramount importance both in the long and short range planning of the issues. You soon will receive a questionnaire which will ask for your comments and preferences regarding all sections of the *Journal,* and your answers will serve as a guide in formulating its future contents and policies. It is hoped that every physician will respond by giving serious thought to the filling out of the questionnaire and its return.

Time Near for Filing Reports and Resolutions

Now is the time for all members of the Texas Medical Association to be looking ahead and planning for the forthcoming annual session to be held in Galveston, April 21-25. Advance thought and work on the part of officers and committees in preparing their annual reports and on the part of all members in submitting any resolutions they may have well in advance of the convention can expedite the proceedings of the House of Delegates.

The delegates need time to study the various annual reports and resolutions in order to act appropriately without undue delay on all items of business before the House. Too, completion of the business of the House rapidly would leave time for the delegates to take advantage of the scientific programs being offered. For faster, better action, the Constitution and By-Laws of the Association (Chapter VI, Section 12) requires that each officer, council, and com-

mittee submit a written report of its year's activities and accomplishments to the Executive Secretary at least 60 days in advance, this year by February 20, so that they may be printed in full and mailed to each delegate 30 days prior to the annual session.

Also to allow adequate time for delegates to consider as many proposals in advance as possible, the Executive Council in session in Austin September 11, 1955, recommended that physicians planning to present resolutions to the House be urged to submit them to the Executive Secretary 30 days before the meeting for duplication and distribution to members of the House. This of course would not mean that resolutions could not be submitted originally at a meeting of the House of Delegates, but it is hoped that many of them can be studied early.

Dr. Hobart O. Deaton of Fort Worth, speaker of the House of Delegates, has stressed the importance of having all reports and resolutions in by the suggested deadlines, and if at all possible earlier than the proposed dates. The business of the Association can be transacted rapidly yet thoroughly at the annual session if all doctors who have reports and/or resolutions to submit will do so without delay.

Proposed Constitutional Amendments

Several proposed amendments to the Constitution and By-Laws of the Texas Medical Association, presented to the House of Delegates at the Fort Worth annual session, will be up for a vote at the 1956 meeting in Galveston, April 21-25. It is important for each member of the Association to study the proposed changes individually, discuss them with other doctors at county society meetings, and let his delegate know how he feels about them.

In accordance with Article XIII, Section 1, of the Constitution, the two possible amendments to the Constitution and three to the By-Laws respectively, follow for the information of each member:

Intern and Resident Members.—The Board of Councilors in its supplementary report to the House of Delegates at the 1955 annual session proposed amending Article II, Section 1, paragraph 3, of the Constitution to read as follows: "Members of county medical societies who are serving internships and residencies in hospitals, as a part of their educational qualifications, and who are not in private practice, may be elected by the county societies as 'intern members' or 'resident members.' When so elected, intern and resident members shall be entitled to all of the privileges of membership in the Association, except the right to vote and hold office, provided that they pay the annual dues as required in the By-Laws and that their names are duly reported in the annual report of the county societies."

Annual Session Advance Planning.—With the idea that planning for the annual session three years in advance rather than two would assure the Association of the best available facilities for the preferred dates, the Council on Scientific Work recommended that the Constitution be amended so that the first part of Article VI, Section 2, will read: "The time and place for holding each annual session shall be fixed by the House of Delegates three years in advance. . . ."

Indoctrination Program.—The Board of Councilors recommended that Chapter VIII of the By-Laws be amended by adding a new section to read as follows: "Section ..... The Indoctrination Committee shall be a special committee composed of the Chairman of the Board of Trustees, the Chairman of the Board of Councilors, the Chairman of the Committee on Public Relations, the Chairman of the Council on Medical Economics, and the Chairman of the Council on Medical Jurisprudence whose duty it shall be to provide the indoctrination program to be given at the meeting of the Executive Council in September and January of each year."

The Councilors further proposed amending Chapter X, Section 4, by adding a new paragraph to read as follows: "Members during their probationary period shall attend at least one indoctrination program to be given at the meeting of the Executive Council in September and January."

Probationary Membership.—The amendment of Chapter X, Section 4, paragraph 2, of the By-Laws to read as follows was recommended by the Councilors: "Component county societies shall provide a probationary period for applicants seeking membership in their county society of twenty-four (24) months. New members accepted on a probationary basis shall have all the privileges of regular membership in the society, except intern and resident members shall not

have the right to vote or hold office. However, at the end of the probationary period, as provided in the Constitution and By-Laws of the component county society, the member shall again be considered by the board of censors of said component society and elected by the county society before his membership can become permanent."

Compulsory Attendance.—One further change was proposed by the Board of Councilors, the amendment of Chapter X, Section 4, by adding a new paragraph to read as follows: "All active members shall attend at least thirty per cent (30%) of the regular meetings of their component county society."

Items introduced at the 1955 meeting and up for discussion at the forthcoming annual session, which will require changes in the Constitution and By-Laws if adopted, include the provisions that the Vice-President shall become the President-Elect, that the Committee for Liaison with the State Bar of Texas should be made a standing committee, and that a Council on Industrial Health should be established on a permanent basis with overlapping terms of office.

Probation, Indoctrination, And Attendance

Hoping to strengthen medical organization by assuring a better informed and more regularly convening membership, the Board of Councilors last April introduced some amendments to the Constitution and By-Laws of the Texas Medical Association. They would provide for a compulsory period of probationary membership during which the prospective member would be required to attend an indoctrination program given by the Association and require attendance at no less than 30 per cent of county medical society meetings per year to remain in good standing (June, 1955, *Journal,* pp. 389-390). These amendments will be acted upon during the annual session in Galveston, April 21-25.

A vague uneasiness has disturbed many physicians concerned over the welfare of basic medical organization—a feeling that too many of their fellows take their membership in the medical society for granted and neglect it for the sake of specialty group and hospital staff meetings. Proponents of the contemplated amendments believe that if a doctor is rewarded with membership in a county medical society only after an apprenticeship in which he becomes aware of the significance of such membership and his responsibilities toward it and if he is required to keep in close touch with its activities to retain his membershp, not only the society but the doctor will benefit.

Opponents of the measure introduced by the Councilors, although favoring the objectives, have raised the question of practicality of these specific provisions. They point out that no allowance is made for the indoctrination programs already being presented effectively by several county societies or for the hardship that some doctors attempting to get established in practice would undergo if required at a specific time to attend an indoctrination program at one place in Texas. They wonder if compulsion is the best way to build loyal attendance and interest. Too, they dislike the idea of the red tape of record keeping and enforcement.

The amendments dealing with probationary membership, indoctrination, and compulsory attendance have evoked considerable interest already and undoubtedly will be debated fully on the floor of the House of Delegates. It is proper that delegates learn now what their colleagues think so that they can discuss the matter intelligently and vote with conviction in Galveston.

Pay Your Poll Tax

ORIGINAL ARTICLES

Steroids in The Management Of Rheumatoid Arthritis

M. D. LEVY, JR., M. D.

Houston, Texas

THE report of the remarkable antirheumatic action of cortisone by Hench, Kendall, and their team of co-workers[3] in April, 1949, has stimulated a great resurgence of interest in the problems presented by patients affected with rheumatoid arthritis. The initial flurry of enthusiastic hopes of quick cures of the disease changed to a cautious pessimism regarding the therapeutic use of the steroids in the management of rheumatoid diseases. With our present experience and knowledge of the action of the steroids, cortisone and hydrocortisone, it would be equally as wrong to deny every patient the possible benefits of these drugs as it would be to administer it to everyone in whom we establish the diagnosis of rheumatoid arthritis.

To use these drugs best we must understand the indications and contraindications as presented by each case individually. We should have a full understanding of the natural history of rheumatoid arthritis, and most important of all, it has to be positively stated that the steroids are only an adjunct to a good general program of management of the disease. Without a complete appreciation of this, the physician and patient are courting disaster.

The contraindications to the use of steroids are well known; most important are the coexistence of active tuberculosis, diabetes, hypertensive cardiovascular disease, heart failure, osteoporosis, history of bleeding peptic ulcer, and an obviously unstable personality make-up. The first requisite for the consideration of use of the steroid must be the absence of any of the contraindications. Secondly, the physician should be certain that he is dealing with active rheumatoid arthritis. Finally, the physician should evaluate each candidate for steroid therapy as an individual problem. Those patients whose disease is relatively mild may be handled best in a more conservative manner following the procedures which have been giving satisfactory results for many years before the cortisone era. In general, women do not tolerate steroid therapy as well as men. This is especially true of women past the menopause. In this respect it is well to keep in mind that postmenopausal women are more likely to develop extensive degrees of osteoporosis while on steroid therapy for prolonged periods.

If the degree of rheumatoid activity in any given patient is such that the usual means of physical therapy are difficult or impossible to accomplish, the administration of the steroids may be of great help in the institution of this type of schedule. If a patient is the bread winner of the family and his disease is such that he is unable to continue work and hence place the economic status of the family in jeopardy, the careful use of steroids may enable the physician more rapidly to mobilize this patient and return him to a gainful occupation. A careful estimate of the degree and extent of the active rheumatoid process will help the physician in making a rough estimate as to the approximate dosage requirement of the steroid as well as the approximate degree of response which may be expected. In general, the milder diseases of a less extensive degree of joint involvement will obtain better improvement on relatively smaller doses of the drug.

HYDROCORTISONE

Hydrocortisone in the free alcohol form is the steroid most frequently used in the systemic treatment of rheumatoid arthritis. It possesses an antirheumatic activity of approximately 1.2 to 1.5 times that of cortisone acetate when given to patients orally. In addition, it has a slightly smaller degree of hormonal effects as compared with cortisone acetate given in comparable antirheumatic doses. This slightly greater disproportion between the antirheumatic effects and hormonal effects is the primary reason

Read before the Texas Club of Internists, Houston, February 25, 1955.

for the selection of hydrocortisone as the steroid of choice in the management of rheumatoid arthritis.

It is the opinion of most rheumatologists that the aim in therapy is to obtain maximum satisfactory relief and improvement with the minimum dose which will produce these benefits. It should be carefully explained to the patient that he is sacrificing some measure of potential benefits for the added safety of smaller doses and to increase the possibility that he may receive therapy over prolonged periods of time with a reduced chance of developing significant hormonal effects of the steroid.

The initial dosage may be relatively high, in the vicinity of 100 to 120 mg. a day, although often with less severe disease, this is not necessary. After the initial period of one to three days with the larger doses, the schedule should be gradually but progressively reduced to the minimum maintenance dose for the individual patient being studied. Women patients, especially those past the menopause, should have the dose reduced to 30 mg. daily, or less if at all possible. Men will tolerate 40 to 60 mg. a day if such is necessary. Larger maintenance doses should be used only if all other measures have been met with failure, and one is dealing with a disease which is relentlessly progressing and which may result in total invalidism of the patient if heroic measures are not taken.

The maintenance dose of hydrocortisone should be changed only upon advice of the physician. It is of extreme importance that these patients be kept under regular observation during the time they are taking steroids. There is a great tendency for patients to buy the drug and to attempt their own regulation. Such procedures not only can bring about inadequate control of the patient, but also will subject him to serious dangers of the many complications possible from this form of therapy. We are all aware of the natural tendency of rheumatoid arthritis to develop remissions and exacerbations spontaneously. Advantage may be taken of this fact, and the average daily maintenance dose of hydrocortisone should be changed at infrequent intervals corresponding to these exacerbations and remissions.

While under long-time maintenance therapy with hydrocortisone, patients should have a moderate restriction of sodium intake and special attention should be given to insure extra potassium and protein in the average daily diet. Attention must be given to the potentialities of the enhancement of usually mild infections and the possibility of infections being masked by the use of adrenocortical steroids. Extra care must be given these patients when they encounter any increased stress such as an accident or when contemplating surgery. It is of value to give them cards to carry indicating the time of institution of hydrocortisone therapy as well as their average daily dose.

INJECTION

In cases of rheumatoid arthritis in which the number of involved joints is small, consideration may be given to utilizing hydrocortisone acetate by direct intra-articular injection. This technique also may be used in patients who have had a more generalized disease but in whom most of the active process has been adequately controlled by other measures such as systemic hydrocortisone, gold therapy, and use of salicylates, leaving one or two joints which need additional control for improved comfort or function. Intra-articular hydrocortisone may be utilized in any joint of the body except the joints of the spine. The procedure is contraindicated if there is any question of the possibility of specific infection arthritis. The dose used will vary generally with the size of the joint to be treated. The interphalangeal and metacarpo-phalangeal joints will require no more than 10 to 15 mg. The larger joints such as the hip, knee, or ankle usually respond better with 25 to 50 mg. There will be some improvement following any injection of this drug, but the duration of benefit varies greatly from patient to patient, and in my experience it has not been possible to predict in advance which patients will get a satisfactory degree of benefit for a period which will make such a procedure practical. It is my belief that significant improvement should persist for at least one week following the injection in order for this procedure to be considered a practical approach to the management of the active process in this particular joint.

The technique for the injection of the various joints of the body is fairly simple, with the possible exception of the hip. Details of the technique may be found in any of the standard texts on the subject of rheumatic diseases, and in addition, some of the drug companies supply well illustrated brochures outlining the commonly used procedures for the injections of hydrocortisone. Whenever possible, all joint effusion should be aspirated prior to the instillation of the hydrocortisone. This is done to minimize dilution of the drug within the joint and hence increase the likelihood of good benefit.

Complications of the use of intra-articular hydrocortisone are rare. Scrupulous attention to asepsis is obviously of extreme importance, and careful observation of the injected joint should be made because it is possible that an impending infection may be completely or nearly completely masked by the action of the steroid within the joint. Prompt and intensive antibacterial therapy, after cultural studies have been

made, often will salvage a joint which otherwise may be virtually destroyed by a septic arthritis which has gone unrecognized.

COMPLICATIONS

Most of the complications of the use of systemic hydrocortisone result from its hormonal effect on the body. These are well known and will not be listed here. In 1952, Slocumb gave a report at the American Rheumatism Association meeting entitled "Relative Cortisone Deficiency Simulating Exacerbation of Arthritis."[6] I would like to quote rather freely from this paper to call attention to this less frequently discussed complication of steroid therapy. He emphasized the need for thorough knowledge of the individual reactions of each patient with rheumatoid arthritis before cortisone was given, compared with the symptoms in each case. The following paragraphs are from his description of what he termed "hypercortisonism":

When a patient with rheumatoid arthritis is on high cortisone dosage, he may have rheumatic manifestations resulting from relative cortisone deficiency despite having body levels of cortisone far in excess of normal. This is referred to hereinafter as "hypercortisonism." Patients on a constant dose of cortisone have profound suppression of their adrenal cortical function as evidenced by low 17-ketosteroid excretion, poor eosinophil response to ACTH and other signs. It appears that tissues of the body adjust to the high concentration of cortisone in such a way that transitory signs and symptoms of relative deficiency of cortisone occur at periods when there is an increase in need for cortisone, i.e., with exertion, stress, infection, etc., and also when the effectiveness of the last dose of cortisone is falling off. There is an apparent temporary relative cortisone deficiency in the tissues even though large doses of cortisone are being administered. If the more profound complications of "hypercortisonism" are to be avoided or minimized, the patient must be carefully studied and questioned so that dosages will be appropriately reduced and especially so that dosages will not be increased due to misinterpretation of symptoms. The "hypercortisone" patient does not remember details well and may be reluctant to complain of new symptoms. For example, a patient with "hypercortisonism," after being at work a few hours, may have pain and quickly become fatigued and depressed. A housewife may feel strong enough to go shopping but in the middle of the shopping trip she is likely to take a taxi home because she is so exhausted. A period of rest, usually sleep, will "reprime" such patients so that when they waken again they can again go about moderate activity.

A careful analysis of a patient during these episodes will reveal a recurring pattern of symptoms, with any one of several symptoms predominating.

At first these periods are of only short duration, an hour or two, later they may be brought on by little exertion and last much of the time. During these short periods of *cyclic* change patients are fatigued and feel weak. Associated with the fatigue they are emotionally upset, may cry easily, and be more irritable than usual; this is in contrast to their feeling, after rest, of being able to do things. However, even after rest, they feel rather frustrated and have a restless drive. With the fatigue they also usually complain of aching, stiffness, pain, soreness—they may use any of these terms. When these symptoms predominate they are convinced they have a rheumatoid flare; yet on close analysis these symptoms are different from their precortisone arthritic pattern. With the reaction of "hypercortisonism" already described, there is only slight, if any, increase in synovial swelling unless trauma is a factor. It must be remembered that synovitis in some joints may persist even with "hypercortisonism." The complaints are out of all proportion to any objective increase in intraarticular synovial reaction. *Tenderness* also is *less* than would be expected from the complaints; but, if the reaction of "hypercortisonism" is severe, there may be tenderness which is muscular, periosteal, and fibrous as well as articular. When tenderness is present patients have an exaggerated "touch-me-not" reaction. With the first squeeze they may cry out, but, with subsequent pressure over the same area, will tolerate firm pressure. A rest period after a dose of cortisone produces little or no true subjective stiffness. The symptoms of aching, stiffness, pain may be attributed to inactivity or rest, but are actually more related to the length of time since the previous dose of cortisone. Such symptoms are relieved more by the next dose of cortisone than by mild activity or aspirin. The flares which occur longest after the last dose of cortisone, such as one the first thing in the morning, may be minimized by re-arranging the dosage schedule. The reaction of "hypercortisonism" is the same in men and women. However, a large majority of the patients seen with this reaction have been women, because they tolerate cortisone less well than men and, interestingly enough, need less than men for therapeutic effect. Most women with 50 mg. a day developed some of the signs of "hypercortisonism" and many post menopausal women with 37.5 mg. a day manifest "hypercortisonism."

Many of the rheumatic symptoms of "hypercortisonism" also occur in hypocortisonism. However, in hypocortisonism there are certain important differences. With gradual withdrawal of cortisone, most patients experiencing "hypercortisonism" notice symptomatic improvement without withdrawal symptoms, i.e., a gradual disappearance of the cyclic swings of aching and fatigue, and a release from the mental restlessness. Symptoms actually referable to joints and muscles may remain negligible. A few patients will notice with each reduction in dosage—however small—mild withdrawal symptoms, usually for a few days to a week or 10 days. . . . The aching, soreness, and stiffness, feeling of depression and emotional instability and fatigability are most pronounced with exertion and just before the next dose of cortisone is due. . . . These symptoms do not mean a flare in the rheumatoid arthritis. The patient can be assured that these mild symptoms will rarely last more than one to two weeks for each reduction of dosage.

This report was based on studies of patients treated with cortisone only because hydrocortisone had not become available in sufficient quantities at the time. The same type of reaction has been observed to occur with the administration of systemic hydrocortisone as well, so that when this steroid is used in the management of patients with rheumatoid arthritis, we must be constantly on guard to be aware of the development of the group of symptoms described by Dr. Slocumb. The therapeutic problems which may arise from the misinterpretation of symptoms produced by the so-called state of hypercortisonism are obvious.

OTHER COMPOUNDS

In the years following the introduction of cortisone to our therapeutic regimen, many workers in the field of endocrinology and especially rheumatology have been searching for other steroid compounds which would exhibit greater antirheumatic activity and lesser hormonal activity. Several derivatives of pregnenolone were studied, and each had a short-lived flurry of excitement amongst clinicians and some investigators who advocated their use in the management of rheumatoid arthritis. It is now felt by most rheumatologists that these drugs have no antirheumatic activity. In 1952, Robinson[5] at the University of Michigan reported studies on a drug which had a complete dissociation between the antirheumatic activity and hormonal activity. This drug was corticosterone and was shown to be highly effective in controlling Addison's disease, but it possessed no antirheumatic activity even in very large doses. During 1954 much attention was directed toward the 9 alpha halogenated hydrocortisones, which possess a marked increase in both antirheumatic activity and hormonal activity. Studies[1] carried out in the latter half of 1954 have indicated, however, that the use of these drugs was not as practical and useful as the original hydrocortisone because of their profound sodium and water retaining properties. Aldarsone, formerly known as electrocortin, has been shown to be the most highly active hormonal substance for the control of adrenal insufficiency, as small as 1 to 4 micrograms a day being adequate to control many patients with Addison's disease. The Mayo Clinic group[4] recently has reported that this drug in doses as high as 1 mg. a day possesses no antirheumatic activity.

The search for a more ideal drug for the management of rheumatoid arthritis recently received a great stimulus when Dr. Joseph Bunim of the National Institutes of Health and the Institute for Arthritis and Metabolic Diseases made a report to the interim session of the American Rheumatism Association in November, 1954. This report was repeated for the Texas Rheumatism Association in Galveston in December, 1954, and printed in *The Journal of the American Medical Association* in January.[2] The two products reported on are synthetic steroids prepared by the Schering Corporation, called Metacortandralone and Metacortandracin.* They are chemically related to hydrocortisone and cortisone respectively, differing in each instance only by an additional double bond at the 1-2 position in the A ring of the steroid nucleus. Metacortandracin recently has been released for sale under the trade name of Meticorten. These two steroids are similar in their antirheumatic and metabolic effects.

The metabolic studies reported by Dr. Bunim clearly show the remarkable chemical effects of these two drugs in the human body. These steroids possess an antirheumatic activity of approximately two to three times that of hydrocortisone. Carefully controlled metabolic studies, prolonged for periods up to 30 days, indicate no increase in the rate of sodium retention, potassium excretion, or protein excretion. Carbohydrate metabolism is unchanged and there was no instance of water retention observed. In no case was there produced an elevation of the blood pressure. These studies were done with dosage levels varying from 30 mg. to 50 mg. a day, which is sufficient to produce virtually a complete suppression of rheumatoid activity in the patients studied. That there is some hormonal effect from these drugs is indicated by a distinct drop in the circulating eosinophils and a significant reduction in the urinary 17-ketosteroids. Only the passage of time will give us the information which we need concerning the benefits and/or toxic effects of these drugs over long periods of administration. However, Dr. Bunim has pointed out in his preliminary observations that the enhanced potency of these two drugs is not accompanied by a proportionate increase in the frequency or severity of undesirable side effects. These new steroids therefore possess an augmented therapeutic ratio. The maintenance dose in his cases varied with the severity of the arthritis and ranged between 5 and 25 mg. daily, from which patients have obtained close to maximal objective and subjective improvement.

It is possible that Dr. Bunim's report on these two synthetic steroids may mark the beginning of the end of the cortisone and hydrocortisone era. This will be true if the original studies are corroborated by other workers. However, until that day actually is upon us, we must remember that the steroids are only adjuncts in the management of rheumatoid arthritis, and to achieve maximum benefit and to prevent crippling deformities resulting from this disease, physicians must avoid merely writing a prescription for a few pills and handing it to a patient and expecting him miraculously to cure himself. Each patient with rheumatoid arthritis must be carefully considered as an individual with a chronic generalized disease, and a full and complete program of management, which may include steroids, should be applied. Only with these principles in mind can much needless crippling and deformity be prevented.

SUMMARY

A discussion of the principles of the use of steroids in the management of rheumatoid arthritis has been

*Now known as prednisolone and prednisone, respectively.

presented. Special attention has been given an infrequently discussed effect of steroid administration which has been called "hypercortisonism." The available data on the new steroids, Metacortandracin and Metacortandralone, have been reviewed.

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Dr. Levy, 601 Hermann Professional Building, Houston.

Adrenocortical Insufficiency In Infants

Management

THEODORE C. PANOS, M. D.

Galveston, Texas

ADRENOCORTICAL insufficiency in infants is being recognized with increasing frequency. The management of this disorder is complex, requiring meticulous attention to numerous important details, and represents a challenge to the attending physician. Improvement in the understanding of the pathologic physiology involved and the availability of potent hormone replacement preparations in recent years have led to impressive therapeutic successes.

Early recognition of the disease is of paramount importance and may be difficult. There is as yet no entirely satisfactory means by which an exact and pinpoint diagnosis can always be made, and reliance, therefore, must continue to be placed on critical clinical observation. In a recent report,[1] an analysis was made of the salient features of 16 cases of adrenocortical insufficiency in infants studied at the University of Texas Medical Branch since 1948. The onset was acute in 4, with rapid development of crisis. In the remaining 12, the onset was insidious and the clinical picture so typical as to constitute a syndrome with the following characteristics:

1. Onset within the first week of life.
2. Persistent dehydration.
3. Failure to gain.
4. Early vomiting, frequently projectile ("pseudopylorostenosis").
5. Polydipsia and polyuria.
6. Occasionally diarrhea.
7. Relatively late development of anorexia and listlessness, harbingers of crisis.

Positive diagnosis was made most frequently by the demonstration of the pathognomonic serum electrolyte changes (decreased sodium and chloride, increased potassium) in association with any combination of the findings just listed. The ACTH-eosinophil test was of limited value in establishment of the diagnosis. It was apparent that the fundamental defect in this disorder is in the adrenocortical control of electrolyte and water balance. Evidence of glucocorticoid deficiency was adduced in only 1 patient.

DR. THEODORE C. PANOS, *from the Department of Pediatrics, the Endocrine Clinic, and the John Sealy Memorial Laboratory for Clinical Research, University of Texas Medical Branch, read this paper before the Section on Pediatrics at the Texas Medical Association Annual Session in Fort Worth, April 26, 1955.*

The management of adrenocortical insufficiency centers about four principles: individualization of care; intensive therapy to bring under control; establishment of a maintenance regimen; and reinforcement during period of stress.

ADRENOCORTICAL CRISIS

Adrenocortical crisis is the natural end result, of course, in the untreated case. It is most commonly precipitated by acute infections but also by trauma (for example, circumcision) and certain drugs. In patients under treatment, crisis also may be precipitated by the premature reduction in dosage or withdrawal of sodium chloride or desoxycorticosterone acetate (DOCA), especially the former. The sequence of events in the development of crisis seems to be as follows:

1. Excessive loss of sodium and chloride in the urine ("salt diabetes").

2. The loss of water into urine, accompanying sodium and chloride loss, and the loss of water into the intracellular space in order to compensate for hypotonicity due to extracellular electrolyte loss.
3. The reduced absorption of sodium chloride and water from the gastrointestinal tract.
4. Constriction of plasma volume with the production of shock and azotemia.

Elevation of the serum potassium level contributes to this clinical picture and is due to increased retention as a result of adrenocortical insufficiency and to concentration as a result of constriction of plasma volume. In very fulminating cases, crisis occasionally occurs in the absence of serum electrolyte changes.

Emergency measures are required to manage the acute crisis. It is imperative to guarantee continuous intravenous therapy and an immediate "cut-down" should be done, since valuable and critical time may be wasted with ordinary techniques under the circumstances of circulatory collapse. The most important measure is to overcome shock and restore renal function. Blood is ideal for this purpose and should be pushed in at a rate of about 5 ml. per minute for a total of 20 to 30 ml. per kilogram of body weight. Plasma is a good substitute for blood, and 6 per cent Dextran, particularly if dispensed in a saline solution, also would be suitable. Because normal saline is always immediately available and effectively complements blood in the management of shock, it is usually the first substance to be infused. Since it also provides the ions specifically deficient in this disorder, its early use is doubly indicated. It should be given in amount and at a rate similar to that described for blood and should be followed by blood. The intravenous or intramuscular administration of a circulatory stimulant such as norepinephrine (Levophed) or phenylephrine hydrochloride (Neosynephrine) also may be advisable. Of course, provisions of external warmth and oxygen inhalation should be carried out as routine procedures. Handling the patient must be minimized as much as possible. The use of barbiturates and narcotic preparations is contraindicated.

Concurrently with these antishock measures, whole aqueous adrenal cortical extract (ACE) should be given in large amounts. This valuable substance provides both mineral corticoid and glucocorticoid effects, each 100 ml. being equivalent in potency to about 7 mg. of DOCA, 170 mg. of corticosterone, and 66 mg. of cortisone. It is difficult to stipulate exactly how much should be administered except to say "give enough." The following schedule is suggested:

a. 3-5 ml./Kg. of body weight intravenously as an immediate ("Stat.") dose; then
b. 1-2 ml./Kg. intravenously every 1-2 hours until the patient is distinctly much improved; then
c. 1 ml./Kg. intramuscularly every four hours until the patient's condition is stabilized, which is usually at least 48 hours; then
d. gradual diminution of dosage as maintenance therapy is instituted.

The adequacy of ACE alone as hormone replacement during crisis has been demonstrated repeatedly. However, it is probably advisable also to give intramuscular cortisone in moderate amounts (10 to 20 mg. daily) for "sustaining" effect. Hydrocortisone, the predominant glucocorticoid produced by the human adrenal cortex, recently has been made available in intravenous form. It is considerably less expensive than ACE and can be stocked in greater supply. It has little mineral corticoid effect. The role of this substance as a substitute for or adjunct to ACE in the management of acute crisis remains to be determined. It doubtless will prove to be a valuable addition to the therapeutic armamentarium.

The third major provision in the therapy of crisis is the replacement of electrolyte and water deficits and the replenishment of carbohydrate stores. The fluid requirements during the first 24 hours may be as high as 300 to 500 ml. per kilogram of body weight and thereafter no less than 150 ml. per kilogram. Electrolyte repletion is satisfactorily accomplished by the use of isotonic saline solution, which should be given in the amount sufficient to supply at least 3 to 5 Gm. of sodium chloride (roughly 300 to 500 ml.) or no less than 80 ml. per kilogram. It should be given in a 5 per cent dextrose solution in order to combat any tendency toward hypoglycemia and to restore glycogen deposits. To the infusion should be added abundant amounts of the water soluble vitamins, particularly vitamin C. Vitamin K also should be given. Because infection so often precipitates crisis and to prevent complicating infection, a potent broad-spectrum antibiotic should be added to the infusion.

MAINTENANCE REGIMEN

Following stabilization over a period of approximately 72 hours, maintenance therapy must be established. The substances available for this purpose are sodium chloride, DOCA, and cortisone or hydrocortisone. The utility of newer steroid preparations such as aldosterone and 9-alpha fluorohydrocortisone has not been determined as yet.

The most important single medication is sodium chloride, the use of which is indispensable to the successful maintenance of the patient with adrenocortical insufficiency. The amount which seems to be required by infants is surprisingly high when compared to the amounts usually prescribed for adults. A daily supplement of at least 3 Gm. of sodium chloride is usually necessary and at times this must

be increased to 5 to 6 Gm. daily. The prescribed amounts of salt may be added to the whole day's formula or may be administered in teaspoon doses of a solution containing 1 Gm. per teaspoon. Once an effective dose has been ascertained, it should be continued at this level; the premature reduction in dose or withdrawal of salt rapidly leads to the development of adrenocortical crisis.

The administration of DOCA should be begun as soon as the crisis is over. Here again, the requirements for infants of this substance are higher than would be estimated in comparison with adult requirements and are in the range of 1 to 3 mg. daily. Only the injectable form should be used in infants. The mode of action of this substance is to promote the renal retention of sodium and water and the excretion of potassium. Because of its potency, the patient must be observed carefully for signs of toxicity. These are excessive weight gain, edema, hypertension, and cardiac damage or failure. The dangers of hypokaliemia are apparent, and supplementation of the diet with potassium is sometimes necessary, even though milk is fairly rich in potassium (35 milliequivalents per liter). Adequate supplementation is provided by 1 Gm. of potassium chloride which contains about 13.5 milliequivalents of potassium. Repeated determinations of serum chloride and electrocardiograms serve as a good guide for therapy. Hypertension may occur fairly late and may persist for several weeks, even after the DOCA is discontinued. It must be remembered that DOCA is completely ineffective without salt. This combination in appropriate doses will satisfactorily control the vast majority of infants with adrenocortical insufficiency. After prolonged periods of maintenance with combined medication, many infants can get along with salt alone, but it is hazardous to depend on salt alone because such patients are more susceptible to the development of crisis from any stress, particularly infection. Therefore, chronic maintenance always should be with some specific hormonal therapy, DOCA and/or cortisone, in addition to the salt. Even during satisfactory maintenance with DOCA and salt, the addition of small amounts of cortisone often improves the well-being.

Cortisone or hydrocortisone, in small doses, probably should be used in all cases. Certainly it should be used if hypoglycemia has been identified or malaise or failure to gain persists after the institution of salt and DOCA. Cortisone must be used cautiously, since the administration of excessive amounts will result in negative nitrogen balance, failure to gain or grow, and increased susceptibility to infection. Excepting cases of adrenocortical insufficiency associated with the adrenogenital syndrome, cortisone should not be given in the excess of 12.5 to 25 mg. daily. An advantageous attribute of cortisone is the fact that it can be administered by mouth. Certain patients can be satisfactorily maintained on cortisone and salt alone after a prolonged period of stabilization on DOCA, salt, and cortisone.

The adequacy of a maintenance regimen should be evaluated repeatedly according to the following criteria:

1. Prevention of weight loss and establishment of steady weight gain without edema.
2. Signs of clinical improvement: cessation of vomiting and diarrhea, sense of well-being and alertness.
3. Maintenance of normal serum electrolytes, blood pressure, and electrocardiogram.

Whenever signs of over-dosage appear, it is wise to reduce the DOCA first, and then the salt very cautiously, and at all times adequate intake of potassium must be assured.

It is of the utmost importance that the maintenance regimen must not be changed for several weeks and preferably not before two to three months. At this time the DOCA may be tapered off gradually in order to determine whether or not it will be necessary to implant pellets or to use desoxycorticosterone trimethylacetate, an effective long-acting preparation which can be injected at monthly intervals. It is at this time that the addition of small amounts of cortisone, if not already in use, may reduce the need for DOCA or actually serve as a substitute for DOCA. However, complete reliance should not be placed on the ability of cortisone to substitute for DOCA, since it definitely failed to do so in 3 of our patients.

Reinforcement of maintenance regimen with ACE and/or cortisone should be carried out during intercurrent infection, trauma, or any episode of diarrhea or vomiting, since any of these may precipitate an acute crisis, particularly the infection. It is for this reason that continuous prophylactic administration of an antimicrobial preparation is advisable in all cases of adrenocortical insufficiency.

SUMMARY

The management of adrenocortical insufficiency in infants is briefly outlined, based on experience with 16 cases.

Crisis demands emergency intravenous therapy in order to restore blood volume, renal function, electrolyte deficits, and carbohydrate stores. The use of aqueous adrenocortical extract is described.

Following stabilization, early maintenance therapy with DOCA and salt should be established. Small amounts of cortisone or hydrocortisone probably should be given in all cases. The primary importance

of salt is emphasized. DOCA should be given by daily injection for several weeks before attempting a change to long-acting medication. Criteria for evaluating adequacy of the maintenance regimen are described.

The importance of continuous prophylactic antimicrobial medication is stressed.

Reinforcement of the regimen with ACE and/or cortisone during the stress of infection, trauma, or gastrointestinal upset is important.

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Dr. Panos, Department of Pediatrics, University of Texas Medical Branch, Galveston.

The Problem Of Amyotonia Congenita

CHARLES BINNEY, II, M. D.

Harlingen, Texas

THE difficult task of accurate diagnosis of muscular weakness in infants and children is faced by every physician dealing with these age groups. The purpose of this discussion is to consider the more common causes of this symptom along with some of the differentiating factors in their diagnosis. A case will be presented to point up the salient features of the amyotonia congenita form of nuclear amyotrophy.

NUCLEAR AMYOTROPHIES

Werdnig[15] in 1891, and Hoffmann[9] in 1893 described a condition in infants which they believed was similar in form to amyotrophic lateral sclerosis in adults. This disease was a muscular atrophy which was rapidly progressive and which they thought was spinal in origin. Thomson and Bruce[14] in 1893 described the same condition and supported their description with microscopic studies of the spinal cord.

Oppenheim[12] in 1900 first described muscular weakness with hypotonia of the limbs and trunk. This weakness did not produce complete paralysis of any part, was almost perfectly symmetrical, and was obvious at birth. Realizing the difference between this disease and acute anterior poliomyelitis, he named it amyotonia congenita and believed it was the result of a prenatal failure of development of skeletal muscles.

Collier and Holmes,[5] however, in 1909 and others since showed that the essential pathologic manifestation of amyotonia was in the anterior horn cells. It is now generally agreed that the muscular abnormalities are secondary to the primary change in the neurons.[1, 2, 3, 4, 7, 8, 10]

The clinical and pathologic similarities and differences between amyotonia congenita and progressive muscular atrophy have led to much controversy and confusion. The original clinical criteria for their distinction are presented in table 1.

TABLE 1.—*The Original Clinical Criteria for Distinction Between Oppenheim's Amyotonia and Werdnig-Hoffmann's Disease.*

Oppenheim's Amyotonia Congenita	Werdnig-Hoffmann's Infantile Spinal Progressive Muscular Atrophy
Congenital	Acquired in first years of life
Most often sporadic	Most often familial
Universal hypotonia	Localized pareses, commencing in pelvic muscles
Muscular atrophy not demonstrable	Distinct atrophy of paretic muscles
Tendon reflexes absent	Absence of tendon reflexes corresponding to degree and extent of atrophy
Dubious response to electric stimuli or "myotonic reaction"	Reaction of degeneration in atrophic muscles
Tendency to improvement	Persistent progression, though with stationary periods

Modified after Marburg, O.: Zur Klinik und Pathologie der Myatonia congenita (Oppenheim), Arb. a. b. neurol. Inst. a. d. Wien. Univ., Liepz. u Wien. *19*:133-154, 1911.

Greenfield and Stern[8] in 1927 and Brandt[3] in 1950 have demonstrated that these conditions are pathologically similar though they do differ clinically in their age of incidence and presenting signs. Buchanan[4] and other writers in the field of neurology choose to consider both these conditions as nuclear amyotrophies and include arthrogryposis multiplex congenita in this classification.

In amyotonia congenita the weakness is noted at birth. In many cases, including the one to be presented, it has been noted that fetal movement during

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pregnancy is less active than might be expected. The weakness is considerable. It is symmetrical, most pronounced in the proximal muscle groups, and more marked in the lower extremities. The muscles of the neck and trunk, including the intercostals, suffer early, and those of the hands and feet rarely if at all. The muscles of the eyes are usually spared as are those of the face and diaphragm. Response to electrical stimulation, both galvanic and farodic, is feeble to absent. The limbs are soft but retain a normal contour. There is classically no fibrillation except in the tongue. Mentality is normal. There are no pathologic reflexes, the deep tendon reflexes are absent, and there is no interference with sensation. Because of the great weakness of the intercostal muscles, the chest is thin and narrow and the cry is feeble. Pectus excavatum is common. With this intercostal weakness, repeated respiratory tract infections are common, and for this reason the life expectancy is no more than a few years.

The body position of such children is dictated by gravity and the passive mobility of the joints. The child is not able to stand or walk or even sit without support. The frequently stated idea that children with amyotonia congenita may improve as they become older is without foundation, and, in fact, it has been shown by Brandt[3] that the disease continues to progress.

In progressive spinal muscular atrophy of Werdnig-Hoffmann, the first symptoms develop toward the end of the first year in a child who has been normal up to that time and who retains his mental integrity. There is a rapidly progressive weakness of the legs and trunk. This weakness is symmetrical and greater in the lower portion of the body. The weakness extends to the shoulders, neck, and eventually the arms. Fibrillation and progressive wasting appear and may also be seen in the tongue and palate. The deep tendon reflexes disappear, sensation remains intact, and no pathologic reflexes appear. Response to electrical stimulation, both farodic and galvanic, is feeble to absent. The muscles of the eyes, the diaphragm, and usually the face escape involvement. Progressive weakness of the intercostal musculature predisposes to respiratory tract infection leading to death usually before the third year. In an adult this would be the clinical picture of amyotrophic lateral sclerosis.

The frequency of various symptoms in 45 cases of progressive muscular atrophy in infants 0 to 1 year old as noted by Brandt[3] are shown in table 2.

Another nuclear amyotrophy in infancy combines some of the features of progressive spinal muscular atrophy with those of amyotonia congenita. Here the weakness and hypotonia are present at birth. However, atrophy and fibrillation of the tongue are also present. Yet, wasting and fibrillation of the skeletal muscles do not develop even in the face of active neuronal degeneration. Intercostal weakness along with weakness and atrophy of the tongue and palate predisposes to a short life expectancy. Such children seldom survive their first year.

TABLE 2.—*Frequency of Various Symptoms in 45 Cases of Progressive Muscular Atrophy in Infants, 0-1 Year Old.*

Symptom	Cases
Universal hypotonia	45
Universal hypokinesia	44
Patellar reflexes absent	36
Patellar reflexes weak (later absent)	3
Patellar reflexes dubious	1
Patellar reflexes not recorded	5
Muscular atrophy palpable	22
Muscular atrophy dubiously palpable	2
Muscular atrophy demonstrated roentgenologically	1
Muscular atrophy not demonstrable	6
Muscular atrophy not mentioned	14
Deformity of chest (intercostal muscular paresis)	24
Paralytic voice	16
Primary contractures	15
Skin changes, subcutaneous infiltrative edema	14
Skin changes, sweat secretion increased	13
Hyperflexibility in one or more joints	12
Simple weak response to electric stimuli	6
Electric reaction of degeneration	4
Electric reaction not tested	35
Constipation	6
Sensibility of skin reduced	5
Fibrillation of muscles of calves	1
Fibrillation of tongue	12
Tremor or muscular fibrillation not mentioned	32
Signs of involvement of muscle regions innervated by cranial nerves (apart from fibrillation of tongue)	17
Oligomimia	6
Unilateral facial paralysis	4
Bilateral facial paralysis	1
Difficulty in sucking	1
Dysphagia	4
Temporal atrophy (?)	2

Modified after Brandt, S.: Course and Symptoms of Progressive Infantile Muscular Atrophy; Follow-Up Study of 112 Cases in Denmark, Arch. Neurol. & Psych. 63:218-228 (Feb.) 1950.

This so-called intermediate or combined form serves as further emphasis that these conditions are but different stages of the same disease process. Arthrogryposis multiplex congenita is included because an affected child has the appearance and the signs of amyotonia congenita with the additional findings of universal shortening of the flexor tendons.[4]

Pathologic findings in the nuclear amyotrophies are confined within the limits of the ventral horn and motor root and are almost purely cellular. There is marked reduction in the number and size of the anterior horn cells. These cells demonstrate defective nuclear structure and poor staining reactions. There is evidence of failure of development in many of the ganglion cells and evidence of active degeneration in

others. Ghost cells are seen at all levels. The histologic pictures in the muscles represent degeneration secondary to defective innervation.

In amyotonia congenita and arthrogryposis multiplex congenita the evidence points to a failure of neuronal development, whereas the emphasis is on active progressive destruction in progressive spinal atrophy. There is evidence of both reactions, however, in all nuclear amyotrophies. The ventral roots show evidence of atrophy and demyelization.

The etiology remains unknown.

Treatment is symptomatic. The treatment is best summed up by Buchanan,[4] who said, "There can be no specific treatment for the nuclear amyotrophies until it is possible to arrest cellular degeneration or restore injured neurones."

TABLE 3.—*Some Other Conditions Showing Muscular Weakness in Their Diagnostic Picture.*

Other progressive degenerative lesions in neuromuscular system
Atypical progressive muscular atrophy
Infantile amaurotic idiocy
Diffuse sclerosis of the brain
Hereditary amyotrophic lateral sclerosis
Dystrophia myotonica
Congenital or very early acquired defects in central nervous system due to developmental disturbances, hemorrhage, or infection
Congenital cerebellar ataxia
Atonic-astatic diplegia (Foerster) and spastic diplegia with initial stage of hypotonia
Birth-traumatic hemorrhages or circulatory disturbances in central nervous system
Mental deficiency with symptomatic muscular hypotonia
Hydrocephalus
Syringomyelia-spina bifida
Postnatal infections in central nervous system or in striated musculature
Encephalitis
Poliomyelitis, anterior acute
Myelitis
Polyneuritis and radiculomeningomyelitis (Guillain-Barré syndrome)
Syphilis
Myositis, dermatomyositis, polymyositis
Tumors of central nervous system
Constitutional affections accompanied by muscular flabbiness or articular laxity
Mongoloid idiocy
Congenital myxedema
Osteopsathyrosis
Arachnodactyly
Constitutional hereditary looseness of joints
Ehlers-Danlos syndrome
Universal muscular hyperplasia
Muscular flabbiness in rickets, digestive disorders, protracted generalized infection, and Addison's disease
Rachitic myopathy
Muscular flabbiness in chronic dyspepsia and other chronic affections
Hypotonia in Addison's disease
Myasthenia gravis

Modified after Brandt, S.: Course and Symptoms of Progressive Infantile Muscular Atrophy; Follow-Up Study of 112 Cases in Denmark, Arch. Neurol. & Psych. 63:218-228 (Feb.) 1950.

OTHER CONDITIONS

Some other conditions with muscular weakness as a part of their diagnostic picture are shown in table 3.

The conditions most often confused with the spinal nuclear amyotrophies include traumatic birth injury. This usually can be recognized on the basis of history, asymmetry, and presence of deep tendon reflexes together with other characteristics. The residual paralysis of poliomyelitis is likely to be asymmetrical and the changes are not progressive. Amaurotic family idiocy, progressive neural muscular atrophy, congenital atonic diplegia, and the various forms of multiple neuritis should be distinguished without great difficulty.

Myasthenia gravis probably deserves special mention. An infant born with this disease has generalized weakness and hypotonia, but he also has a variable weakness of the muscles of the eyes and face. The most striking simple sign of myasthenia gravis is a variable inability to suck which is less marked after sleep. The response of myasthenia gravis to prostigmine is diagnostic.

CASE REPORT

The following case will serve to emphasize again the features of the nuclear amyotrophies.

CASE 1.—S. D., a 5 months old white girl, was admitted to the Children's Hospital, University of Texas, Medical Branch, Galveston, in early October, 1953, with a chief complaint of weakness. The history of the mother's labor, the delivery, and the infant's immediate neonatal period was uneventful. The mother did state that the fetus was inactive during the latter months of gestation. By the end of the first week of life the parents were concerned with the infant's weak cry. When the infant was 7 to 8 weeks of age, breathing difficulty, marked weakness, and inactivity were conspicuous enough to be noticed by the parents. Nursing had become more and more difficult with frequent episodes of coughing and strangling. One month prior to admission the infant experienced a brief episode of cyanosis, and on the day of admission she had a severe episode with choking and became deeply cyanotic and lifeless due to aspiration of feeding. She was revived and referred to the hospital. The family history was noncontributory.

Physical Examination.—The infant lay in the pithed-frog position. Respiration was rapid and difficult with scattered fine inspiratory rales throughout both lung fields. The thorax appeared elongated and moved very little during respiration, and pectus excavatum was obvious. There was no evidence of atrophy or fibrillation. The infant moved very little except her eyes. She moved not at all against gravity. Her facial expression was one of alertness. There

was beginning talipes bilaterally. No deep or superficial reflexes were elicited, and there were no abnormal reflexes.

Laboratory Studies.—Blood studies revealed 11.5 Gm. of hemoglobin per 100 cc., 4,100,000 red blood cells per cubic millimeter, and 11,650 white blood cells per cubic millimeter with normal differential. Serum sodium was 141 milliequivalents per liter, potassium 5.2 milliequivalents per liter, and carbon dioxide combining power 20 mm. per liter. A roentgenogram of the chest revealed the previously mentioned deformity of the thoracic cage and essentially clear lung fields. Electrocardiograms were not remarkable. The cerebrospinal fluid was normal. There was no response to a prostigmine test. A biopsy of the gastrocnemius muscle done by Dr. E. B. Rowe showed degenerative and fibrotic changes consistent with amyotonia congenita.

Course of Disease.—The infant's course in the hospital was progressively downhill, punctuated by numerous cyanotic episodes due to aspiration of mucus and formula. She was tube-fed throughout. Tracheotomy and gastrostomy were considered carefully, but it was decided neither would be really helpful. A trial of cortisone was without benefit. On October 19 the infant experienced a particularly severe episode of cyanosis and stopped breathing, and all efforts to resuscitate (including endotracheal intubation) were fruitless.

Postmortem Examination.—On postmortem studies the lungs showed bronchiectasis and bronchopneumonia. There were toxic and congestive changes in all organs.

The microscopic sections of the skeletal muscles showed changes secondary to neuronal abnormalities. These changes consisted of loss of striation, fibrous and fatty replacement, and hypertrophy of muscle bundles intermixed with normal muscle.

Sections of the spinal cord revealed an absence of anterior horn neurons and occasional evidence of active degeneration.

SUMMARY

In the nuclear amyotrophies the outstanding defect is weakness and hypotonia of the muscles of the limbs and trunk. There is no complete paralysis, and the weakness is greater in the lower extremities. The arms can be raised although there is limitation of power, but the legs do not move against gravity. In spite of this muscular weakness, the child is alert and is mentally normal. This at once distinguishes the nuclear amyotrophies from the group of conditions in which physical weakness is related to cerebral dysgenesis and mental retardation.

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♦ Dr. Binney, The Children's Clinic, 1720 Pennsylvania, Harlingen.

Transient Synovitis of The Hip Joint In Children

KERMIT W. FOX, M. D., and LAWRENCE L. GRIFFIN, M. D.

Austin, Texas

TRANSIENT synovitis is probably the most common condition affecting the hip joint in children. It occurs fairly frequently—certainly more frequently than the few reports in the literature indicate. Whereas this disease is now most popularly known as transient synovitis, it also has been referred to by such terms as transitory arthritis, coxitis serosa, transitory coxitis, coxitis fugitive, coxitis serosa seu simplex, and "observation hip."

The typical case is characterized by the following features: The onset is either abrupt or insidious in a child between 3 and 10 years old and is ushered in by a limp and pain in the hip, thigh, or knee. The

cause most frequently is unclear, but trauma, previous infection, or an allergic state may be associated factors. Signs of infection such as fever, leukocytosis, and elevated blood sedimentation rate, if present at all, are very transient and not prominent features. The roentgenograms consistently show no bony changes, but variable minor soft tissue changes may be noted. Complete recovery will take place in from a few days to usually not longer than two weeks, and no residual damage is expected. The most common and effective method of treatment is rest of the involved joint. Recurrences, whereas occasionally seen, should be viewed with suspicion.

DR. KERMIT W. FOX *read this paper before the Section on Pediatrics at the Texas Medical Association Annual Session in Fort Worth, April 26, 1955.*

HISTORICAL REVIEW

In reviewing the literature on hip affections in children it is apparent that for many years various diseases were described that were not unlike our present day concepts of transitory synovitis. Fairbanks[4] in 1926, when discussing nontuberculous coxitis in the young, seemed to include cases of transient synovitis under the headings of "traumatic synovitis and arthritis" and "subacute and chronic infective arthritis." In the same presentation Platt recognized the existence of a "transitory arthritis, due, presumably, to trauma or infection."

When Butler[1] in 1933 reported a series of 22 cases of transitory arthritis of the hip, he noted how since 1922 the term "observation hip" had been ever more frequently applied to questionable cases rather than readily classing them as tuberculous joints. Out of 25 "observation hips" seen in 1929, 1930, and 1931, only 3 were finally diagnosed as tuberculosis, 19 making a complete and lasting functional recovery, thus being classed as transitory arthritis. Butler stated that at one time these cases of transitory arthritis might have been considered as excellent cures of tuberculous hips.

In 1936, Finder[6] recorded his observations in 22 cases diagnosed in the University of Iowa Orthopedic Clinic from 1916 to 1936. He contributed a pertinent thought by noting that "In transitory synovitis of the hip joint the synovitis constitutes the entire disease, but in other hip joint lesions the synovitis may merely represent the point of departure into any one of several disorders of the hip."

Rauch[10] in 1940 reported 37 patients having 45 attacks of hip joint synovitis. This is the first report to come to our attention in which the feature of recurrence is so striking.

When presenting painful hips in children, Lucas[9] in 1948 briefly and concisely summarized this condition but added no new cases.

Finally, Ferguson[5] in 1954 discussed some aspects in which synovitis was related to Legg-Perthes disease.

We are reporting 23 cases of transient synovitis of the hip. These were selected from private patients seen in our clinic from 1948 to 1954. Approximately half of these patients initially were seen by pediatricians. All of these patients were white, the youngest being 3 years and the oldest 8 years of age at the time of the initial attack. The average age was 5 years. This figure is in close agreement with the average age quoted in other series. The left hip was involved 13 times and the right 12 times. Two of these patients finally developed Legg-Perthes disease, and 2 additional ones had recurrent episodes. The series represents 16 males and 7 females. This definite predominance of males is virtually the same as reported by Butler, Rauch, and Ferguson, whereas Finder and Edwards found an equal sex distribution.

ETIOLOGY

It is apparent that the etiology of this condition still remains generally unknown. In our series as well as in previously reported ones there are a fair number of instances in which no known factor alludes to the cause. In some cases, however, certain factors appear as possible causative or contributing agents. In Butler's 22 cases 13 failed to show any cause, 4 might have been influenced by trauma, and 5 might have been caused by metastases from foci of infection elsewhere. Butler and Finder both felt that infection is the most likely causative factor. Finder found no cause in 12 out of 22 cases, but he listed as possible causative factors trauma and exertion in 6 cases and related infection in 4 cases. Rauch was unable to find any cause in 19 out of 45 reported attacks, but he seemed to lean toward trauma as probably playing a significant causative role, particularly since boys were more frequently affected than girls. He reported 10 attacks related to injury. Eight out of his 37 patients had a family history of allergy. Edwards' thoughts on etiology are expressed in the following quotation: "it is felt most likely that it represents an allergic hypersensitivity or toxic reaction to some other focus of infection in the body."

The 25 attacks in our series showed no apparent seasonal trend. In 6 of these no cause whatsoever

could be found (table 1). Of the 8 attacks in which trauma seemed to be a causative factor, 4 seemed to be the result of definite injury. Two of these were

TABLE 1.—*Etiology of Transient Synovitis in 25 Attacks.*

Cause	Attacks
No definite cause	6
Probably traumatic	8
Possibly associated with upper respiratory infection	5
Following "shots"	2
Possibly on allergic basis	6

falls from a tricycle, another a fall on a rock, and the fourth an impact by a car. In 5 instances the onset of hip trouble started immediately after or during an infection of the upper respiratory tract. In 1 case the onset of hip disease was dated seven days following a tetanus "shot" and in a second case nine days after the administration of tetanus, pertussis, diphtheria, and smallpox "shots." In 5 cases a history of allergy was forthcoming, and in a sixth the synovitis promptly recovered after administration of diphenhydramine hydrochloride (Benadryl). We were unable to note any correlation between the incidence of hip synovitis and specific body type.

PATHOLOGY

It is assumed that the most logical lesion in this condition is a nonpyogenic synovitis of the hip joint. Among the evidence to substantiate this assumption is one recorded report of a biopsy by Finder. Soft tissue changes as represented in some cases on the roentgenogram and described by Hermel and Skarloff,[7] Drey,[2] and Ferguson[5] point toward changes in the synovial membrane and adjacent joint capsule. Finally, no bony changes are seen in the acute stages nor in the follow-up investigation and no narrowing of the joint space is noted. The latter tends to preclude significant involvement of bone or articular cartilage.

Edwards aspirated 2 hips and found xanthochromic fluid. The smear in these was negative and so was the culture of the fluid.

CLINICAL AND LABORATORY FEATURES

Clinical Features.—Of the 25 attacks reported 18 had a sudden or fairly abrupt onset whereas 7 came on more insidiously (table 2). A limp or unwillingness to bear weight on the affected extremity was noted in 23 out of 25 episodes. Limping was mild and intermittent in some and severe and continuous in others. Pain was a complaint in 13 instances, 8 localizing it about the hip itself, 2 in the knee, and 4 in the thigh. In 1 of these cases, knee and thigh pain was present simultaneously. Pain at night was a prominent feature in 4 attacks. Restriction of hip motion of a variable degree was the most consistent finding. It was present in every episode. A low grade fever was noted in 7 instances, and tenderness either over the anterior, lateral, or posterior aspect of the hip was observed 11 times.

TABLE 2.—*Clinical Features of Transient Synovitis in 25 Attacks.*

Feature	Attacks
Onset	
Sudden or fairly abrupt	18
Insidious	7
Limp	23
Pain	13
Hip	8
Knee	2
Thigh	4
Knee and thigh	1
Night pain	4
Restriction of hip motion	25
Low grade fever	7
Tenderness	11

Laboratory Studies.—Tuberculin tests were done in 10 cases, 8 being found to react negatively. No positive reactions were noted. In 3 cases the sedimentation rate was determined and found to be within normal limits. A complete blood count or white cell count alone was done in 9 cases, and the only abnormal finding was a leukocytosis of 12,000 to 14,000 cells per cubic millimeter in 3 cases.

Roentgenograms.—Until the time of Drey's report in 1953, it was generally considered that roentgenograms were essentially normal in cases of transient synovitis of the hip. This author pointed out the presence of certain soft tissue shadows which he thought were pathognomonic for a swelling of the synovial membrane. He had noted changes in the gluteus minimus, obturator internus, and iliopsoas muscles manifested by broadening of these muscle shadows, disappearance or blurring of the adjacent intermuscular septal lines, and an increased haziness and density of the muscle itself. Changes in the iliopsoas muscle called the "iliopsoas sign" were positive in 9 out of 10 cases he observed. In 1954, Hermel and Skarloff and also Ferguson called attention to capsular swelling in these cases. Of the "muscle signs" Hermel and Skarloff most frequently noted changes in the obturator internus muscle. This is referred to as the "obturator sign." Ferguson believed that frequently there was a slight widening of the joint space particularly medically and inferiorly. All

authors still emphasize, however, that in transient synovitis one should not be able to see any changes in the bony texture such as deossification, sclerosis, or destruction. It cannot be overemphasized that in each one of these cases a good quality roentgenogram of both hips is imperative. By at least taking pictures of both hips in the anteroposterior projection one side can be used as a control. When the anteroposterior view is taken, the pelvis should be perfectly parallel to the table. It is desirable also to take a lateral projection. These films should be critically interpreted paying particular attention to soft tissue shadows.

In critically reviewing the roentgenograms in 23 cases (24 attacks) we found that they were essentially negative in 11 instances (table 3). No cases showed any significant bony changes. Abnormal prominence of the obturator internus shadow (obturator sign) was present 4 times; broadening of the iliopsoas muscle (iliopsoas sign) was noted 5 times; and widening of the joint space inferiorly and medially could be recognized 3 times. In only 1 instance did we notice a distinct bulge in the superolateral margin of the capsule. In 4 instances one could appreciate an increased haziness and obliteration of soft tissue septal lines in the region immediately superior and lateral to the femoral neck. The majority of these soft tissue shadows could be interpreted only when the roentgenograms were of optimal quality and when the normal hip could be used as a control.

TABLE 3.—*Roentgenographic Findings in 23 Cases (24 Attacks) of Transient Synovitis.*

Finding	Attacks
Normal roentgenogram	11
Normal bony texture	24
Obturator sign	4
Iliopsoas sign	5
Gluteus minimus sign	4
Widened joint space	3
Capsular swelling superolaterally	1

CASE REPORTS

A few cases in this series are of special interest and merit additional comment.

CASE 1.—V. A. F., a 4 year old white girl, was seen initially on January 6, 1950, with a right-sided limp of three days' duration. She had been having a coryza for the preceding week and also had run into a door two days prior to the onset of symptoms. The physical findings of limited hip motion in all ranges, entirely normal roentgenograms, a white blood cell count of 13,950 per cubic millimeter, and a negative tuberculin test were consistent with the diagnosis of synovitis. Under the routine management, including antibiotic therapy, she made a complete recovery by January 14. On about April 9, almost three months later, she again began to limp on the same side. When she was seen next on May 29, a diagnosis of Legg-Perthes disease was made. The roentgenograms and physical findings were consistent with this.

CASE 2.—C. S. S., a 7 year old white girl, developed pain in the left groin associated with an intermittent limp about two weeks prior to being seen initially on June 12, 1954. Physical examination revealed restricted hip motion and 1 inch atrophy of the left thigh. The roentgenograms of the hip were normal and the tuberculin test negative. By June 25 she apparently had recovered on routine treatment. On about November 1; four months later, she again developed pain and an intermittent limp in the same hip. Roentgenographic examination on December 11 disclosed findings consistent with the diagnosis of Legg-Perthes disease.

This is the only case in our series in which definite muscle atrophy was noted.

It is known that Legg-Perthes disease can start in a rather insidious manner, and, as stated by Ferguson, synovitis "is related to Legg-Perthes disease in that it is potentially preliminary to it." The 2 cases are excellent examples of what appears at the time to be ordinary cases of transient synovitis with the later development of something more serious in the same joint. It remains of interest whether the initial attacks of synovitis really represented the actual onset of the Legg-Perthes process or whether the original synovitis was merely a coincidental unrelated episode.

The next two children had attacks first in one hip followed about a year later in the opposite one.

CASE 3.—J. G., a white boy 3½ years old, limped on the left side for one day on August 9, 1952. On September 3 his limp recurred. The hip movements were restricted, the tuberculin test was negative, and the white blood cell count and differential were normal. The roentgenograms showed slight widening of the joint space and a positive "iliopsoas sign." A diagnosis of transient synovitis was made. By September 19 he made a complete recovery on our usual treatment regimen. On about July 1, 1953, he developed a similar episode of synovitis in the opposite right hip, and this lasted about 16 days. Recovery appeared complete two days after diphenhydramine hydrochloride (Benadryl) therapy was started. In January, 1955, both hips were clinically and roentgenographically normal.

CASE 4.—S. F. T., a white girl 5 years old, developed an attack of synovitis in the right hip on September 25, 1952, and responded readily to treatment, the whole process lasting only about four days. Approximately a year later on August 1, 1953, this patient had a similar episode in the opposite left hip. The affair, however, lasted only about two days. A final check on December 17, 1954, showed both hips to be normal from the physical and roentgenographic standpoint.

FOLLOW-UP STUDY

Follow-up study was possible in 9 cases. Two of these 9 patients subsequently developed Legg-Perthes disease. Of the remaining 7, 6 were restudied in detail an average of 28 months after the onset of symp-

toms of the initial attack. In these 6 cases the follow-up roentgenograms of the hip were normal, and clinically the previously affected hips and corresponding lower extremities showed no obvious abnormal findings.

DIFFERENTIAL DIAGNOSIS

The early correct diagnosis of hip conditions in children is important, for it helps to insure optimal treatment. Early treatment is particularly desirable in the diseases most readily confused with transient synovitis, that is, Legg-Perthes disease and tuberculosis. On the other hand, early overtreatment is unfair and unwelcomed by the parents as occurred in 1 of our cases of synovitis incorrectly diagnosed as Legg-Perthes disease elsewhere with the recommendations of cast immobilization.

Many of the early clinical features of Legg-Perthes disease are so similar to those of synovitis that one must rely primarily on roentgenographic findings to differentiate the two. Kite[8] mentioned three very early findings in Legg-Perthes disease that precede even the decalcification of the metaphysis. These are the "roof sign" (flattening on the lateral side of the upper femoral epiphysis), Waldenstrom's sign (widening of the inferior and medial aspect of the joint), and narrowing of the transverse diameter of the obturator foramen on the affected side as shown on the anteroposterior projection. He also mentioned a fourth less practical finding of an increase in density of the epiphysis as noted by photoelectric meter determination. Somewhat later this increase in density of the head with gross flattening is characteristic.

In tuberculosis the carefully taken history frequently alludes to previous exposure, an insidious and intermittent onset, lack of general well being, and so forth. In the roentgenogram the earliest significant finding is probably the presence of atrophy of bone at the joint, especially in the epiphysis and adjacent acetabulum. Frank early destructive areas in bone most frequently will be noted as marginal lesions adjacent to the epiphyseal line either on the metaphyseal or epiphyseal side.

Any supposed case of transient synovitis that fails to clear in the usually expected period or recurs after recovery should be viewed with suspicion of being something more severe. Both tuberculosis and Legg-Perthes disease run chronic courses but temporarily can show remissions with rest.

Septic arthritis and/or osteomyelitis of the hip ordinarily should present no serious problem in differential diagnosis unless the infectious process is mild and/or the picture clouded by early administration of an effective antibiotic.

There are usually enough general features to help diagnose such conditions as rheumatic fever and rheumatoid arthritis.

TREATMENT

There is general agreement that rest of the involved hip joint is the most important and effective step in the treatment of transient synovitis. This can be accomplished in several ways, but probably the most practical method is to put the patient on strict bed rest. This was done in virtually every attack in this series. Only rarely was the use of crutches permitted and then only in older children having milder attacks. In addition to bed rest traction was used for a few days in 2 episodes, and in 1 case a hip spica was applied briefly to facilitate handling the child. Only 1 patient from out of town was hospitalized. To make bed rest easier and more effective, mild sedatives frequently were given. It has been our practice to have the patient refrain from any weight bearing until there is a free, painless range of motion of the joint. Antibiotics were administered for 15 attacks. It is our feeling that this is probably justified where the attack is associated with or immediately succeeds an infectious process such as an upper respiratory infection. It is probably well to give antibiotics also in cases in which reliable follow-up care at home is questionable. Where hip discomfort, muscle spasm, and marked limitation of hip motion are prominent features, the use of local heat is desirable. An antihistamine drug, diphenhydramine hydrochloride (Benadryl), was given in only 1 attack with complete subsidence of signs and symptoms in the hip within 48 hours. Edwards gave tripelennamine hydrochloride (Pyribenzamine) to 2 of his patients with a history of allergy and reported dramatic lasting recovery in one day. Salicylates were used in only 1 attack in our series. During the early phase of the disease the parents in every case were requested to maintain an accurate temperature record and report any undue elevation.

In 24 attacks of this series treatment was started an average of six days after onset of the disease, and complete recovery from the current attack was noted within an average of nine and one-half days after treatment was started. The total illness lasted an average of approximately 16 days. The duration of illness ranged from 2 to 47 days. The patient who took 47 days to get well was a child struck by an auto, and it is conceivable that the lesions present may have been more extensive than a simple synovitis. We were unable to note any correlation between the length of time the disease existed prior to

treatment and the response to therapy. It is of interest, but without ready explanation, that the duration of the disease and response to treatment was strikingly more prolonged in such older series as Butler's and Finder's and even Rauch's as compared to the more recent group of Edwards'. Edwards' experience in these respects is in close agreement with our own. Of additional interest is the observation that these cases formerly were treated much more intensively.

COMMENT

Some of the more pertinent observations made during the course of this study that warrant emphasis are listed below:

1. Patients who resumed weight bearing before the affected hip had a full painless range of motion usually had immediate recurrence of limp or their recovery period was prolonged.

2. The diagnosis of simple synovitis should be made with reservation in a hip associated with a significant degree of muscle atrophy. Careful follow-up in such a case is in order. Muscle atrophy was noted in only 1 case of ours, and this patient subsequently developed Legg-Perthes disease. Butler is the only other author who makes any mention of observing muscle atrophy. He noted it in only "several" cases.

3. When the roentgenograms are carefully interpreted, positive helpful findings will be evident in some cases.

4. Any case diagnosed as simple synovitis that does not respond readily to treatment deserves progressively more investigation, for the presumed diagnosis may be in error and a more serious disease may be prevailing.

SUMMARY

Twenty-three cases of synovitis of the hip joint in childhood are reported and 25 attacks analyzed. Two patients finally developed Legg-Perthes disease, and 2 additional children had an attack in each hip at different times.

A brief review of the literature is presented.

Positive roentgenographic findings in synovitis of the hip are described in detail.

Differential diagnostic features, particularly as they refer to tuberculosis and Legg-Perthes disease, are discussed.

Several pertinent observations are mentioned under "Comment."

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Drs. Fox and Griffin, 1010 West 19, Austin.

Osteoporosis

J. D. IBARRA, JR., M. D.

Temple, Texas

OSTEOPOROSIS is a pathologic and clinical disease entity evidenced by a decrease in bone tissue due to inadequate bone formation. In osteoporosis, there is little bone matrix—this all important bone matrix being a product of the functioning osteoblasts. These cells are stimulated by the normal stresses and strains to which the bones are exposed when the person moves about.[5] The osteoblasts also secrete the larger part of the alkaline phosphatase which is present in the blood. They require protein to form this matrix, and there are conditions in which the production of

DR. J. D. IBARRA, JR. *is from the Department of Internal Medicine of the Scott and White Clinic.*

protein bone matrix is insufficient because of an abnormal protein metabolism. When the synthesis of protein is insufficient, bone matrix is not formed; thus, replacement of bone substance which has dis-

solved during daily wear and tear becomes impossible and gradual thinning of the bone trabeculae occurs. Calcium and phosphorus can be deposited only in the presence of an adequate matrix; and in osteoporosis, the bone that is present is chemically normal and calcified, the defect lying in the deficient amount of protein matrix being formed.

It is well to emphasize at this point that osteoporosis is a symptom of a generalized disturbance of protein metabolism, and not a disturbance of calcium and phosphorus metabolism. This is in contrast to rickets and osteomalacia, in which matrix abounds and is even excessive, but calcification fails, making the bone weak and pliable. In these diseases, the disturbance is in the metabolism of calcium and phosphorus, and blood levels are low. Since osteoblasts are overactive, there is an increase of alkaline phosphatase.

CAUSES

Since osteoporosis is a defect in protein metabolism, there are several conditions that may enter into its cause (table 1). In osteogenesis imperfecta there is a congenital defect of the osteoblasts, that is, there is an apparent failure of these to form a normal amount of bone matrix. It has been pointed out that in some cases of osteogenesis imperfecta, there are actual increases in the osteoblasts, and these may produce an elevation in the serum alkaline phosphatase.

TABLE 1.—*Causes of Osteoporosis.*

Congenital defect of osteoblasts.
Osteogenesis imperfecta.
Nutritional defect.
Starvation.
Scurvy.
Disuse atrophy.
Localized.
Generalized.
Lack of anabolic stimulus.
Postmenopausal osteoporosis (most common).
Ovarian agenesis.
Eunuchoidism.
Hypopituitarism.
Hypogonadism produced by extrinsic causes.
Roentgen ray.
Surgery.
Senile osteoporosis—combination disuse and gonadal defect.
Excessive protein catabolism.
Cushing's disease or syndrome.
Cushingoid syndromes—administration of ACTH and cortisone.
Thyrotoxicosis.
Defect unknown.
Acromegaly.
Idiopathic osteoporosis.

Osteoporosis may be caused by a nutritional defect, such as starvation, in which a diet inadequate in protein might lead to a negative nitrogen balance. This in turn might make it impossible for the osteoblasts to lay down necessary organic matrix, the first step in the formation of bone. Another nutritional defect, such as hypovitaminosis C, may be a contributory factor in the production of osteoporosis. Ascorbic acid is necessary for the formation of the collagenous material of fibrous tissue structures, including the matrix of bone.[4] Obvious scurvy in adults is relatively rare, but it stands to reason that in malnutritional states the low vitamin C intake may be a factor in the production of osteoporosis.

Osteoporosis may occur, and frequently does, following immobilization of one part or the whole body, and this is called disuse atrophy, or osteoporosis of disuse. Since the stimulus to the osteoblasts to form bone matrix is stress and strain, any immobilization will decrease their activity, and bone resorption continuing, osteoporosis will result. Frequently, the underlying cause of a spontaneous fracture is overlooked and even made worse by immobilization. Atrophy of disuse is probably a factor in the osteoporosis of old age.

The lack of anabolic stimulus is an important causative factor in osteoporosis. Postmenopausal osteoporosis is the most common type of osteoporosis and is due to a protein anabolic defect. In these patients, the etiologic factor is a deficiency of the protein anabolic estrogenic hormone. There is also, in some of these patients, some degree of disuse atrophy due to decreased physical activity.

There are several conditions in which there is a lack of anabolic stimulus, as in the menopause. In ovarian agenesis there is an absence of estrogen, and in eunuchoidism there is a lack of androgen. Also, hypopituitarism, due to a deficiency of the gonadal hormones, may cause osteoporosis. Hypogonadism produced by extrinsic causes may produce osteoporosis. This, again, is due to a lack of anabolic stimulus, and may occur in the female patient who has undergone oophorectomy or has received large doses of roentgen ray to her abdomen and back. The ovarian function has been almost, or completely, abolished and osteoporosis may ensue. In senile osteoporosis the underlying causative factor is a decrease in the protein anabolic hormone factor and, to some extent, atrophy of disuse.

Excessive protein catabolism, as in Cushing's disease or syndrome, is also a cause of osteoporosis. In these patients, the excessive amount of adrenal cortical hormones produces a negative nitrogen balance. This anti-anabolic effect of the adrenal cortical hormones may be produced when large doses of ACTH

and cortisone are administered and a Cushingoid syndrome is artificially established.

Another condition that produces negative protein metabolism, and one in which osteoporosis frequently is overlooked, is thyrotoxicosis. In these patients there is an increased requirement of protein and vitamins, leading to a form of malnutrition. In this disease, in the absence of sufficient protein and vitamin intake, the excessive catabolism of protein for energy may end in a deficiency of protein tissues including bone matrix. From this, one can surmise what may occur if hyperthyroidism appears in a menopausal patient who already has a deficient protein metabolism. It has been proved by some investigators that in thyrotoxicosis there is an increased excretion of calcium.[2]

There are other conditions in which the underlying defect producing osteoporosis is unknown. In acromegaly, osteoporosis may occur, and many etiologic possibilities have been postulated. It is believed that eosinophilic adenomas produce an excessive amount of ACTH, leading to an overproduction of adrenal corticoids, which in turn produce a negative nitrogen balance. These pituitary tumors are known to produce an excessive amount of thyrotropic hormone, producing a thyrotoxicosis, and this may be a possible cause for osteoporosis. Still another theory is that the increased protoplasmic mass in acromegaly requires a higher nitrogen intake to keep in nitrogen balance. It has been established that in acromegaly hypogonadism exists, therefore producing the most common cause of osteoporosis, a lack of estrogens and androgens.[2]

Another condition in which the underlying cause producing osteoporosis is unknown is in the so-called idiopathic osteoporosis. The manifestations are similar to those in postmenopausal or senile osteoporosis, but the patient is not menopausal or senile, nor can any other disorder mentioned be found.

SIGNS AND SYMPTOMS

Backache is usually the most common symptom of osteoporosis. Pain of a radicular pattern also may be present, and pain localized to the ribs is found frequently. These pains may appear after a spontaneous fracture, after a faulty step from a curb, a fall, or lifting a heavy object. Since osteoporosis is more prevalent in the vertebrae, there may be collapse and deformity of these, producing a kyphosis, or leg or girdle pain. Vertebral tenderness and limitation of motion of the spine are found commonly. Examination may disclose shortening of height. Nephrolithiasis also may be present.

The skin usually is parchment thin, and there is a definite loss of elasticity. Gordon[3] has stressed this symptom and states that it goes "hand in hand" with osteoporosis.

Upon radiologic examination, there is increased radiolucency, and trabeculae are "washed out," giving the cortex of the bones the false appearance of increased radiodensity. The vertebrae become thin and the intervertebral disks expand, giving the vertebrae a biconcave appearance, the so-called "fish vertebrae" as seen in figure 1. The distribution of the skeletal

Fig. 1. Osteoporosis of the vertebrae. Note the "washed out" appearance and the biconcave vertebrae.

lesion is generalized, but not always recognized radiologically. The roentgen changes are first recognized in the vertebrae, usually the lumbar vertebrae. In senile and postmenopausal osteoporosis, the vertebrae are more commonly the only bones involved roentgenologically, and the skull, long bones, and ribs less frequently are involved in contrast with Cushing's syndrome, thyrotoxicosis, ovarian agenesis, and eunuchoidism in which all bones are involved.[4] The lamina dura around the teeth, as seen by roentgenogram (fig. 2), is characteristically intact, an important point in the differential diagnosis between osteoporosis and hyperparathyroidism, and osteomalacia, in which this is lost.

Early in the course of osteoporosis, the urine shows a hypercalcuria, a 4 plus Sulkowitch reaction; but later when the bones are exhausted, the Sulkowitch

Fig. 2. Normal appearing lamina dura (left), and absence of lamina dura (right).

reaction may be less than normal. The blood calcium, phosphorus, and alkaline phosphatase levels are normal. An elevated alkaline phosphatase level is strong evidence against osteoporosis. In the acute osteoporosis of disuse in childhood, the rapid liberation of calcium from growing bones may exceed the renal capacity for excretion; this is the only known example of an increased serum calcium level in osteoporosis. The elevated calcium level may lead to the erroneous diagnosis of hyperparathyroidism.[3]

DIFFERENTIAL DIAGNOSIS

In differential diagnosis, it is important to consider the more common diseases that may produce lesions simulating osteoporosis (table 2).

First is multiple myeloma which frequently may begin with the symptoms of osteoporosis; and in the early stages of the disease, the roentgen findings may mimic those of osteoporosis. In multiple myeloma, there are definite differentiating points that make this diagnosis simple. The onset usually is abrupt, the course is progressive, and there is a hyperproteinemia with a hyperglobulinemia. In the urine, albuminuria and Bence-Jones protein can be demonstrated in the majority of patients. Blood studies will demonstrate an anemia and thrombocytopenia. Bone marrow will show the typical myeloma cells. In this disease, blood calcium and alkaline phosphatase levels may be elevated.

Osteomalacia is another disease of the bone that may resemble osteoporosis in some aspects, but here again there are some differentiating points. On roentgen examination, the cortices of the bones visualized are involved, and there is a destruction of the lamina dura about the teeth. The alkaline phosphatase level is elevated, while the calcium and phosphorus levels are low.

TABLE 2.—*Differential Diagnosis of Osteoporosis.*

Multiple myeloma.
Progressive and rapid course.
Hyperglobulinemia.
Bence-Jones protein.
Myeloma cells in marrow.
Blood calcium and alkaline phosphatase may be elevated.
Osteomalacia.
Cortex of bone involved.
Lamina dura destroyed.
Low serum calcium and phosphorus.
High alkaline phosphatase.
Hyperparathyroidism.
Bone cysts.
Cortical feathering.
Loss of lamina dura.
Hypercalcemia with low serum phosphorus.
High alkaline phosphatase.
Metastatic lesions.
Rapidly progressive roentgenographic changes.
Renal insufficiency.
History of renal insufficiency.
Nitrogen and phosphorus retention.
Normal or slightly low serum calcium.
Severe acidosis with low carbon dioxide combining power.

In hyperparathyroidism the bones will have a typical roentgen appearance with cortical feathering, loss of the lamina dura, and the presence of bone cysts. The diagnosis requires the presence of hypercalcuria, hypercalcemia, a decreased serum phosphorus content, and also an elevated alkaline phosphatase level.

Metastatic lesions, when sufficiently diffuse, sometimes may confuse the diagnosis, and blood chemistry studies may be necessary, but they may not clarify the situation. However, in diffuse metastatic bone disease the definite and final diagnostic aid is time.

In some patients with renal insufficiency of long standing, osteoporotic lesions may be visible on roentgenograms. This condition, however, can be differentiated from osteoporosis by the long history of renal insufficiency, nitrogen and phosphorus retention, normal or slightly low levels of serum calcium, and severe acidosis with a low carbon dioxide combining power of the serum. A compensatory hyperparathyroidism may aggravate this condition and produce more decalcification of bone.[5]

Table 3 gives laboratory tests helpful in the differential diagnosis of osteoporosis.

TREATMENT

I wish to emphasize that in osteoporosis due to causes other than gonadal insufficiency, the treatment is obvious in the majority of instances, as occurs in

Cushing's disease or syndrome, thyrotoxicosis, disuse atrophy, and nutritional defects.

When the diagnosis of postmenopausal or senile osteoporosis has been established, the response to hormonal therapy is regular, and as stated by Gordon, "the response of postmenopausal osteoporosis to estrogens or androgens is as regular as the response of myxedema to thyroid substance."[3] Failure of the patient to demonstrate loss of pain and invalidism within three to six weeks strongly suggests that the correct diagnosis was not established.

TABLE 3.—*Laboratory Aids in Differential Diagnosis of Osteoporosis.*

Laboratory Test	Normal in Osteoporosis	High	Low
Serum calcium	9-11 mg./100 ml.	Hyperparathyroidism.	Chronic nephritis. Osteomalacia. Hypoparathyroidism. Malabsorption syndromes (sprue, steatorrhea, etc.). Malnutrition.
Serum phosphorus	3-4.5 mg./100 ml.	Hypoparathyroidism. Chronic nephritis.	Osteomalacia. Malabsorption syndromes. Malnutrition. Hyperparathyroidism.
Serum alkaline phosphatase	8-14 King-Armstrong units/100 ml.	Hypoparathyroidism. Osteomalacia. Fractures (bone repair). Malabsorption syndromes. Malnutrition.	
Serum total protein	6.5-8 Gm./100 ml.	Multiple myeloma (increase in globulin fraction).	Malabsorption syndromes. Malnutrition.
Urinary calcium (Sulkowitch's semi-quantitative test)	High in early stages; normal or low in late stages.	Hyperparathyroidism. Chronic nephritis.	Hypoparathyroidism. Malabsorption syndromes. Osteomalacia. Malnutrition.

Estrogen, alone, has been used in the treatment of postmenopausal osteoporosis, Premarin, 0.6 to 2.5 mg.; or ethinyl estradiol, 0.02 to 0.1 mg.; or stilbestrol, 0.5 to 2.0 mg., being given daily for 20 to 40 days, and then omitted for ten days. This dosage, then, is repeated for an indefinite time. It has been found that this type of treatment may cause withdrawal bleeding in the majority of patients.

Methyltestosterone, alone, has been advocated by some physicians and is given 5 to 20 mg. daily in sublingual absorptive tablets (Linguets) for about six weeks, and then discontinued for about two weeks. After this period, the treatment is resumed. This hormone may produce acne, hirsutism, hoarseness, and an undesirable increase in libido in women patients. This form of therapy probably should be limited to osteoporosis in men due to a hypogonadal state.

I advocate the combined estrogen-androgen treatment (table 4), which has proved satisfactory and has fewer ill effects than treatment with estrogens or androgens alone. The effect of estrogen and androgen in combination on the retention of calcium and protein is greater than that of either hormone alone.[1, 4] Premarin, 1.25 mg., is given daily for six weeks, and at the same time Metandren Linguets, 10 mg. daily are begun and are administered for 12 weeks. At the end of 12 weeks, all hormones are discontinued for about two to four weeks. Then, another cycle of treatment is begun, and the treatment is continued for an indefinite period. With this therapy, withdrawal bleeding rarely occurs and the small doses of androgen seldom produce masculinizing symptoms. In men, in whom the problem of withdrawal bleeding does not exist, the combination of Premarin, 1.25 mg., with methyltestosterone, 10 mg., is given throughout the six weeks' period; and this is followed by a rest period of from two to four weeks. The rest period from hormones may have to be reduced since I have found that some patients, after two to four weeks

TABLE 4.—*Treatment of Osteoporosis.*

Combined estrogen-testosterone.
- Female.
  - Premarin, 1.25 mg. daily for six weeks.
  - Metandren Linguets, 10 mg. daily for 12 weeks, beginning simultaneously with Premarin.
  - Rest period of hormone treatment of about six weeks.
- Male.
  - Premarin, 1.25 mg. with methyltestosterone, 10 mg. daily for six weeks.
  - Rest period of about two to four weeks.

Diet.
- High protein, high caloric.
- Vitamin C, 250 mg. daily.

without hormones, will begin to complain of their original symptoms. On reinstitution of the hormones, these symptoms readily subside.

In the early stages of osteoporosis, during the phase of hypercalcuria, that is, when the Sulkowitch test is positive, this finding can be used as a guide for the dosage of hormones. Sufficient hormones should be given to convert the Sulkowitch reaction to normal.

Patients are instructed concerning a high protein diet and advised to take vitamin C, at least 250 mg., daily. The diet and vitamin C are recommended continuously without interruption.

I would like to emphasize that whether estrogens are used alone or in combination with androgens, the breasts and pelvis should be checked every six months. If vaginal bleeding occurs at times other than with the withdrawal of estrogen, dilatation and curettage are indicated.

CASE REPORTS

CASE 1.—Two years ago, this 70 year old woman came to the clinic because of dysuria, marked urinary frequency, and lower abdominal pain, plus low back pain and aching in the left shoulder. A urologic diagnosis of interstitial cystitis was made, and she was treated at frequent intervals for her bladder condition. For her back and shoulder pain, she was advised to take salicylates and to apply heat to the painful areas. About six months later on one of her visits to the Department of Urology, she complained that the back and shoulder pain was becoming severe, keeping her awake at night and incapacitating her in the daytime; hence, she was referred to the Department of Internal Medicine for specific diagnosis and treatment.

Physical examination revealed a pale, elderly woman who appeared to be chronically ill. Manipulation of the left shoulder and percussion of the spine produced pain. Laboratory findings at this time revealed the results of the urinalysis to be negative. Hemoglobin and complete blood count were within normal limits. Total serum proteins were 7.3 Gm. per 100 ml.; serum albumin, 4.1 Gm. per 100 ml.; and serum globulins, 3.2 Gm. per 100 ml. with an albumin-globulin ratio of 1.2:1. Roentgenograms of the cervical and dorsal spine revealed osteoporosis of all bones visualized.

The patient was instructed concerning a combined estrogen-testosterone regimen and dismissed to return for observation. This treatment schedule included Premarin (1.25 mg.) daily, for six weeks; Metandren Linguets (10 mg.) daily, for 12 weeks; with a high protein, high caloric type of diet, plus vitamin C (250 mg.) daily. After 12 weeks of therapy, all hormone administration was to be interrupted for a six weeks' period, then resumed according to the schedule.

Observation in 30 days demonstrated the patient's physical condition to be improved. She had gained 4 pounds in weight, and the pain caused by osteoporosis had decreased remarkably. About three months later, a bloody vaginal discharge appeared when Premarin was withdrawn. Although the pelvic examination was negative, she was advised to return in two weeks. Upon reexamination, bleeding had stopped, and, again, the pelvic examination was negative. At this time, the patient reported that her bladder symptoms had subsided shortly after institution of hormonal therapy for the osteoporosis and that she had a good appetite. She had gained 12 pounds.

This patient has been observed every three to six months during the past year, and her improvement has been remarkable. Once, after three weeks without hormone therapy, back pain recurred. Immediately, the regimen was altered. The patient was advised to resume hormone therapy after a three weeks' instead of the prescribed six weeks' withdrawal period. With this modification of treatment, she has become active, and pain in her back or extremities has not recurred. On comparative roentgenograms, made upon admission and one year after the initial examination, remarkable changes have not occurred.

This case is an example of senile osteoporosis in a woman who responded well to combined estrogen-testosterone therapy. Because of recurrence of pain, the rest period from hormones had to be shortened. This case also demonstrates the bleeding which may occur when estrogen is withdrawn, and it stresses the importance and necessity of physical examination in this event.

CASE 2.—A 66 year old restaurant owner came to the clinic because of severe pain in his lower dorsal and upper lumbar regions. This discomfort began following the lifting of a heavy object and had been present for two months. The pain, radiating anteriorly in a girdle fashion, became worse progressively, and the man had required codeine at frequent intervals for relief.

The physical examination was difficult because any movement of the spine caused pain. The patient held his back rigidly, and a marked dorsal kyphosis had developed. The skin was rather thin and nonelastic. The remainder of the physical examination was noncontributory, and the patient was hospitalized for investigation and treatment.

Laboratory studies on admission revealed the results of the urinalysis and the Bence-Jones test for proteins to be negative. A complete blood count was within normal limits. Total serum proteins were 5.7 Gm. per 100 ml.; serum albumin, 3.4 Gm. per 100 ml.; serum globulins, 2.3 Gm. per 100 ml.; and albumin-globulin ratio, 1.4:1. The serum alkaline phosphatase was reported to be 4.3 units per 100 ml. by the King-Armstrong method; serum phosphorus was 4.25 mg. per 100 ml.; and serum calcium was 10 mg. per 100 ml. Results of Sulkowitch's test were normal.

Roentgenograms of the dorsal and lumbar spine showed marked osteoporosis. Multiple fish vertebrae, several showing compression fractures associated with some scoliosis, were observed. Roentgenograms of the skull showed slightly diffused osteoporosis.

While the patient was in the hospital, a treatment program consisting of Premarin (1.25 mg.) with methyltestosterone (10 mg.), daily, plus a high protein, high caloric diet and a multivitamin preparation was instituted. After seven days of therapy, the pain decreased, and the patient was able to walk with less discomfort. Upon dismissal, he was advised to continue the prescribed therapy for six weeks, then to withhold the hormones for two weeks—the original regimen to be resumed after the two weeks' period.

Follow-up on this patient revealed that he has continued to improve and that now he is able to operate his restaurant.

This case demonstrates the onset of pain after apparent trauma. By roentgenogram, compression fractures were demonstrable at a later date. Here again, hormone therapy, along with diet and vitamin sup-

plements, proved to be successful in the treatment of this patient.

CASE 3.—Because of severe low back pain radiating to both hips, this woman, aged 58 years, was admitted to the hospital. Pain had appeared suddenly while she was stooping and was so severe that she had to be carried to bed. After two weeks of bedrest, the pain persisted, becoming worse on changing positions. Also, sneezing and straining aggravated the pain.

The physical examination was difficult to perform as the patient held herself rigidly, and any movement caused severe pain. On palpation, the lumbar and sacral spine appeared tender. Her general condition seemed poor, and her skin was extremely thin and nonelastic.

Laboratory studies on admission revealed the findings of the complete blood count to be normal. Urinalysis was negative for Bence-Jones proteins. Sulkowitch's test showed excessive calcium in the urine. Other findings of clinical interest were as follows: total serum proteins, 5.3 Gm. per 100 ml.; serum albumin 3.4 Gm. per 100 ml.; serum globulins, 1.9 Gm. per 100 ml.; albumin-globulin ratio, 1.7:1; serum alkaline phosphatase, 7.2 King-Armstrong units; and the sedimentation rate (Westergren method) was 30 mm. per hour. Sternal marrow was normocellular, with no evidence of multiple myeloma. Roentgenograms of the lumbar spine and pelvis revealed osteoporosis of all bones visualized. Fish vertebrae formation and compression fractures of lumbar vertebrae 1, 2, and 3 existed.

Combined estrogen-testosterone therapy was instituted as in case 1. Although Sulkowitch's test still revealed excessive calcium in the urine, the patient was dismissed from the hospital in about two weeks. At this time, her pain had decreased greatly, and her general condition was much improved.

In six weeks, she returned to the clinic for observation. By wearing a properly fitted corset, she had been able to be up and about her house for a month. Sulkowitch's test showed a normal amount of calcium in the urine. The sedimentation rate was 12 mm. per hour. Roentgenograms of the lumbar spine did not demonstrate an increase in the osteoporosis or further compression of the vertebral bodies.

This case demonstrates again the sudden onset of severe pain in osteoporosis. Although the initial Sulkowitch test revealed excessive calcium in the urine, this constituent returned to normal after therapy. It must be remembered that this patient's general condition was considered to be so poor on admission that multiple myeloma was suspected, but this diagnosis was ruled out by laboratory examinations.

CASE 4.—This woman, aged 65 years, was admitted to the hospital for treatment of a fracture of the left tibia and fibula. On turning over in bed, about one month after the application of a cast, the patient experienced severe pain in the anterior portion of the right side of the chest. Roentgenograms revealed fractures of several ribs, plus generalized osteoporosis of the bones visualized.

A detailed history revealed that moderately severe and progressive low back pain had been present for the past five years. The patient had lost weight and had become weak because of anorexia and anemia. Since her leg fracture, she had been in bed most of the time.

Physical examination revealed nothing remarkable except that the patient appeared chronically ill, pale, listless, and thin. Her skin resembled tissue paper.

A complete blood count disclosed a hypochromic anemia. Other laboratory findings of clinical value included serum proteins, 6.4 Gm. per 100 ml.; serum albumin, 2.8 Gm. per 100 ml.; serum globulins, 3.6 Gm. per 100 ml.; with an albumin-globulin ratio of 0.7:1; serum calcium, 11.2 mg. per 100 ml.; serum phosphorus, 4.4 mg. per 100 ml.; serum alkaline phosphatase, 6.7 King-Armstrong units per 100 ml.

After two weeks of hormone therapy, the patient's appetite increased, she began to gain weight, and her back pain decreased. The fractures of the left tibia and fibula began to unite shortly after treatment was begun. She was seen at monthly intervals for about six months, and her improvement was remarkable.

This case illustrates the complications that can arise in a senile person who has a fracture and is confined to bed. Osteoporosis of disuse is superimposed on the existing senile osteoporosis. In this patient, a nutritional factor may have been present.

SUMMARY

The multiple causes of osteoporosis have been outlined. The basic defect is in the negative balance of protein metabolism, preventing normal osteoblastic activity. The calcium and phosphorus metabolism is normal. The essential characteristics of other bone diseases from which osteoporosis must be differentiated are discussed.

The basic treatment consists of producing a positive nitrogen balance which is accomplished by the administration of gonadal hormones, a high protein diet, and vitamin C. The combination of estrogens and androgens seems to be much more effective than the use of either hormone alone.

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Dr. Ibarra, Department of Internal Medicine, Scott and White Clinic, Temple.

Pan American Medical Women's Alliance

The Fifth Congress of the Pan American Medical Women's Alliance will be held in Santiago and Vina Del Mar, Chile, March 6-14. Information may be obtained from the secretary, Dr. Eva F. Dodge, 2124 West Eleventh, Little Rock.

Coccidioidomycosis Of Bone

LOUIS J. LEVY, M. D.,
CUVIER P. LIPSCOMB, M. D., and
HENRY C. McDONALD, JR., M. D.

Fort Worth, Texas

THE purpose of this paper is to review the characteristics of coccidioidomycosis, particularly of bone and joint, and to stimulate interest in looking for the disease in areas heretofore not considered to be endemic. The areas considered to be endemic for coccidioidomycosis are the San Joaquin Valley of California, lower California coastal region, parts of southern Utah, Nevada, large areas of southern Arizona, New Mexico, and western Texas. Outside of the United States, other endemic areas are found in Sonora and Chihuahua, Mexico, the Chaca of Argentina and the highlands of Venezuela.[5]

With the rapid transportation facilities of today, large numbers of people are being brought in and out of these areas constantly. Thus, case reports are appearing in places remote from endemic areas. Endemic areas have in common such factors as hot summer weather, mild winter weather, a period of precipitation during the year, and a definite period of three to four months without precipitation, sparse vegetation, dust in dry seasons, and winds to scatter.[2] Coccidioidomycosis or coccidiomycosis (both are correct) was described by Posadas in 1892. The fungus causing the disease (Coccidioides immitis) was demonstrated by Ophuls and Moffit in 1900.[9]

DR. LOUIS J. LEVY *is a diplomate of the American Board of Orthopedic Surgery. This paper was presented for the Texas Orthopedic Association in Fort Worth, April 25, 1955.*

The fungus has a vegetative or saprophitic phase, which is found outside the living host (with the exception that the saprophitic phase occasionally is found in large pulmonary cavities). This phase is characterized by production of mycelial, branching, arthrospores and chlamydospores. It is easily grown on Sabouraud's medium, carrots, wood strips, cactus, and potatoes.[4] In the laboratory, the old cultures become powdery and constitute an extreme hazard to technicians working with the fungus. The fungus fragments (arthrospores, chlamydospores, and so forth) usually enter the body through the respiratory tract and go through a sporogenic or parasitic phase. Spherules, 2 to 10 microns in diameter, containing several to several hundred endospores develop. The spherules rupture, expelling into the tissue endospores which in turn form new spherules. The fungus is killed in four minutes at 60 C. It is pathogenic for rodents, dogs, rabbits, monkeys, and other animals. Spores are found in the soil of endemic areas. Transmission from man to man or animal to man has not been demonstrated, although theoretically this would seem possible.

Coccidioidomycosis is more prevalent during dusty, summer months. Male cases outnumber female cases 2 to 1. It is much more common in the colored races. Highest incidence of the disease is during the third and fourth decades; however, it has been seen in a 2 weeks old infant born during a dust storm in an endemic area.[1] In endemic areas, there is a high incidence of the disease. Seventy-five per cent of cases are subclinical.

There are two distinct forms of coccidioidal disease, primary and disseminated. The primary disease presents a picture of mild influenza-type respiratory disease, but occasionally is more severe with a pneumonia-like picture. Chest roentgenograms show hilar peribronchial thickening and pneumonitis. Thin walled cavities of varying size also may occur. They characteristically have little surrounding reaction. This finding offers a useful differential point in helping to rule out tuberculosis, which closely resembles coccidioidal disease in many respects. Patients with pulmonary cavitation may have intermittent hemorrhages, which require surgery, but usually they heal uneventfully. Twenty per cent of primary cases develop erythema nodosum in one to two weeks after the onset of the disease. These erythematous spots become tender but disappear leaving a brownish pigmentation within two weeks. About one-third of primary cases develop pain and mild swelling of the joints, which disappear without residuum in about a month.

The coccidioidin skin test becomes positive at about four weeks after infection. The complement fixation test is positive during the disease but becomes negative with recovery. The skin tests remain permanently positive. The sedimentation rate is usually elevated, along with an increased eosinophil count. False positive Wassermann and Kahn tests may occur with the disease. No specific treatment is known.

If the organism is not halted at the hilar lymph

nodes, dissemination by blood stream and lymphatics occurs. Almost any tissue in the body is attacked by the fungus with the exception of the gastrointestinal tract. This is another contrasting differential point between tuberculosis and coccidioidal disease.

In cases of coccidioidomycosis, one of every 100 white male patients and 10 of every 100 Negro male patients develop the disseminated disease, of which 50 per cent of white cases and 85 per cent of Negro cases end fatally.[2] Dissemination, if it occurs, takes place within the first few months of the disease. Dissemination should be suspected in cases with prolonged fever and meningeal and other severe symptoms. High complement fixation titer (usually 1:32 or higher) is found in disseminated cases and may be used to follow the course of the disease.[9] The coccidioidin skin test may be negative in the disseminated form, and therefore the negative coccidioidin test does not rule out the disease. The lesions are granulomatous and destructive. Bone lesions are found only in the disseminated disease. There seems to be a predilection for cancellus bone, especially the bony prominences. Cartilage offers no barrier for spread of the infection. Sequestration is rare. There is usually only moderate reaction of the surrounding bone to the infection. Joints are usually secondarily infected by extension from bone. The clinical course is one of pain, swelling, redness, progressing to fluctuation, ulceration, and draining sinuses.

Diagnosis is made from microscopic identification of the characteristic double-refractile spherules. These may be found in sputum, bone abscesses or granulomas, infected joints, and other involved tissue. Organisms are often elusive and may not be seen on every microscopic field. Guinea pig inoculations and cultures may be necessary at times to help demonstrate the organisms.

Treatment of the disseminated disease has been disappointing. Many patients show spontaneous healing with the host and parasite living together in an apparently peaceful balance of power. Many drugs have been tried without success. Others have shown promise, but not conclusively so. Some of these drugs are gentian violet, thymol, colloidal copper, potassium tartrate, iodides, antimony, sulfonamides, antibiotics (penicillin seems to stimulate growth of the organism), actidione, prodigiosin, extract of buttercup, crystal violet, isoniazid, quinacrine hydrochloride, fungicidin, stilbamidine, and histidine. Ethyl vanillate is under investigation and shows some promise.[3] Vaccines, convalescent blood transfusions, and radiation therapy also have been tried, without conclusive results.

Surgery, in the form of excision of bone lesions and synovectomy of involved joints, appears to be worth while in some cases.[9, 11] General nonspecific measures, similar to those used in the treatment of tuberculosis, seem to be the best that we can offer the patient at present.

CASE REPORT

The following is an illustrative case of coccidioidal granuloma of bone.

History.—C. S. W. was observed in our clinic December 13, 1954, giving a history of having had recurrent episodes of pain and swelling in the left knee for 11 or 12 years. The patient was examined in a clinic in 1943, receiving a complete physical examination, but no definite diagnosis or recommendations for treatment of the knee were made. Episodes of the pain became more severe and frequent until several weeks prior to examination in our clinic the pain had become continuous. Generalized swelling of the knee had been developing gradually. Slight twisting of the knee when walking caused severe pain. Weather changes did not affect the knee. Rest afforded the patient the only real relief from discomfort. The patient stated that he had had upper back and abdominal pain for many years also. This was vaguely localized and described as recurrent, penetrating, severe pain, shooting through the epigastric area into the back. The abdominal and back pain were always simultaneous. Food, drink, or exercise did not affect this pain. The patient had had a complete gastrointestinal work-up by a local internist on several occasions with no remarkable findings. On later questioning, the patient stated that he had spent about six months, off and on, in Mexico in the 1930's. He had lived in West Texas (Coleman) for many years. The patient could recall no recent or remote respiratory disease other than occasional common cold and several mild bouts of pleurisy. He had never had a productive cough.

Examination.—Examination revealed a white man, aged 45, in apparently good health. He walked with a moderate limp of the left knee. There was an obvious generalized swelling of the left knee joint, but there was a full range of motion in the joint. Palpation revealed a tender, firm

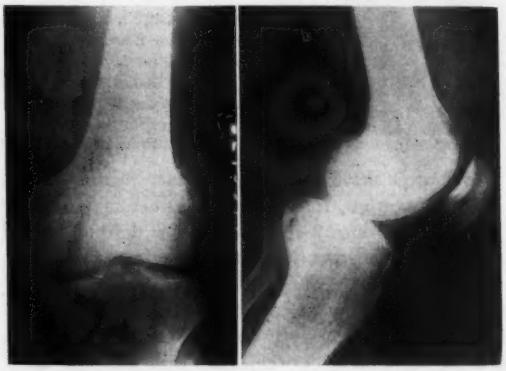

Fig. 1. Roentgenograms made August 17, 1943, revealing a slight rarified area on the posteromedial aspect of the upper tibia on the lateral view, not noticed until films made later showed a definite destructive lesion here.

swelling of the posteromedial aspect of the upper tibia and the lateral aspect of the upper tibia, just anterior to the head of the fibula. The ligaments of the knee were apparently normal. There was no tenderness to deep palpation in the epigastrium and both upper quadrants. No masses were found. Back examination was not remarkable.

Fig. 2. Films of the knee made November 23, 1954, revealing further destruction of the posteromedial aspect of the upper tibia just beneath the joint surface, measuring 3 to 4 cm. in diameter. A small defect of the same type is noted in the lateral portion of the upper tibia.

Roentgen Studies.—Roentgenograms made August 17, 1943 (fig. 1) revealed a slight rarified area on the posteromedial aspect of the upper tibia on the lateral view which was not noticed until roentgenograms made at a later date showed a definite destructive lesion here. Films of the left knee made November 23, 1954 (fig. 2) revealed further destruction of the posteromedial aspect of the upper tibia just beneath the joint surface, measuring 3 to 4 cm. in diameter. A small defect of the same type was noted in the lateral portion of the upper tibia. There seemed to be some expansion of the posteromedial aspect of the tibia in the region of the larger cystic area. Surrounding bony reaction was mild to moderate. Back and chest films made July 31, 1950, and June 1, 1952, revealed no remarkable abnormalities other than mild hypertrophic changes of the spine.

Routine laboratory determinations, including complete blood count, urinalysis, and Kline test, were within normal limits.

Surgery.—No definite diagnosis of the knee lesions was made. Surgical excision of the lesions and pathologic studies of the tissues removed were planned. On December 15, 1954, surgical excision of the cystic areas was carried out and the cavities packed with merthiolate bone-bank bone. A chronic inflammatory process was encountered with a grayish-pink, semigelatinous material being removed from the cystic area. The cortex had been perforated by the process in one area, with extension of this material into the overlying soft tissues. The joint was opened and was found to contain excessive joint fluid. The synovia was thick, boggy, and covered with shaggy grayish-pink villi. A small portion of the synovia was removed. Immediate study

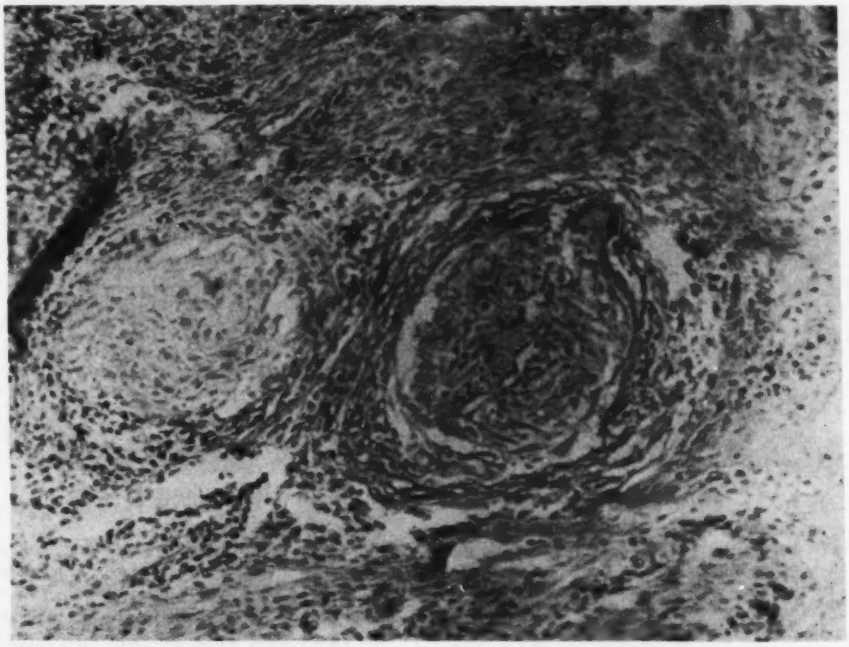

Fig. 3. Photomicrograph of the specimen removed from bone at surgery, showing the typical granulomatous lesion of coccidioidomycosis, containing a double-refractile spherule.

of the material was carried out by the pathology department while the patient was on the operating table, and a diagnosis of chronic, nonspecific, granulation tissue was returned. The wounds were closed without further synovectomy.

The formal pathologic reports on the following day revealed that the granulomatous type of tissue reaction contained tubercle formation, with lymphocytic and plasma cell infiltration and Langhan's giant cells. A few double-refractile spherules were found, giving us our diagnosis (fig. 3 and 4). A Coccidiodes immitis culture also was grown on Sabouraud's medium from the tissue removed.

Postoperative Course.—The postoperative course of the patient was uneventful. He was given a skin test with coccidioidin, 1:100. This test was strongly positive. A complement fixation test (performed by the Public Health Communicable Disease Center in Chamblee, Ga.) was positive with a titer of 1:8. Isoniazid, 100 mg. three times a day, and dicrysticin, 1 cc. twice a day, were given for two weeks postoperatively. The patient's wounds healed well. Roentgenograms made February 21, 1955 (fig. 5) showed apparent healing progressing in the bone grafted areas.

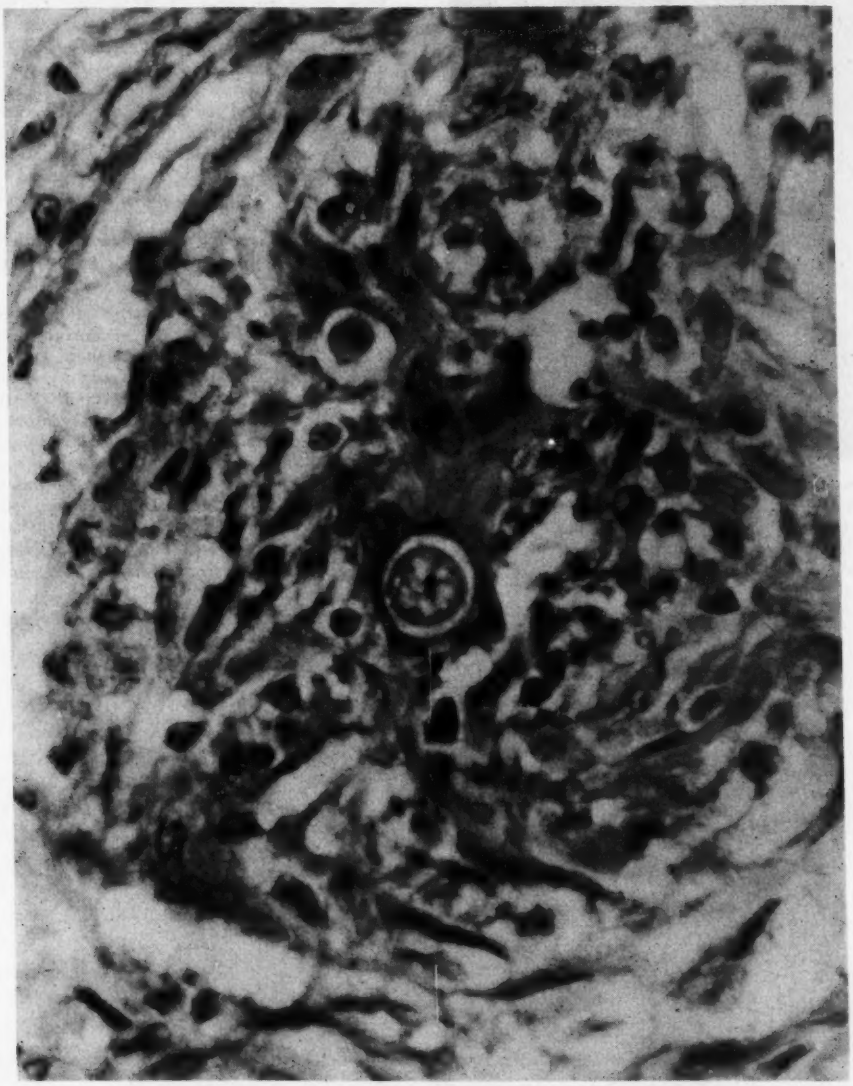

Fig. 4. Oil emersion magnification of the lesion shown in figure 3.

On April 4 the patient was walking with a slight limp. His knee pain had been completely relieved and the swelling was subsiding. He had a full range of extension but lacked about 15 degrees of full flexion. The abdominal and back pain remain unchanged, and the patient will undergo further studies, including further interval complement fixation tests, in the future.

SUMMARY

The general features of coccidioidomycosis have been reviewed. A case of coccidioidal granuloma of bone has been presented. The case represented is a coccidioidal infection of 12 years' duration which has responded favorably to surgical excision of the lesions, although it is too early to be sure of the outcome. In view of the other reported cases, complete synovectomy of the knee may be necessary in the event of a flare-up.[9, 11] Long-standing abdominal and back pain have not yet been explained. These might well be another manifestation of coccidioidal granuloma.

It is predicted that there will be a rising instance of coccidioidomycosis outside of the endemic areas, making knowledge of the disease important to all doctors.[7]

Fig. 5. Roentgenograms made February 21, 1955, revealing apparent healing progressing in the bone grafted areas.

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Public Relations: Its Roll In Organized Medicine

LEO E. BROWN

Chicago, Illinois

THE advice given by Dr. D. W. Cathell, professor of pathology in the College of Physicians and Surgeons at Baltimore, in 1882, on office management and public relations, was somewhat different from what we think of today. In a paper entitled "The Physician Himself," he said:

> Do not allow the ladies of the family to lounge about your office, read your books, answer the office bell, etc., lest it repel patients. Both messengers and patients prefer to meet either the doctor or his servant rather than ladies.

LEO E. BROWN, *Executive Assistant to the General Manager in Charge of Public Relations, American Medical Association, was a special guest speaker at the Texas Medical Association's Public Relations Conference in Austin, September 10, 1955.*

Do not let your office be a lounging place or a smoking room for horse jockeys, dog fanciers, gamesters, swaggerers, politicians, coxcombs, and others whose time hangs heavily on their hands.

Have a copy of the fee table framed and hung in a semi-prominent position in your office that you may refer patients to it whenever occasion requires. . . . Of course you may omit its cash enforcement towards persons with whom you have a regular account.

Never let a bony horse and a seedy-looking or unsuitable kind of carriage stand in front of your office for hours at a time, as if to advertise both your poverty and your paucity of practice.

Do not squirt tobacco juice around you at your visits, or have your breath reeking with its fumes, or with those of cloves, cardamom, alcohol, dead beer, etc., or you will unavoidably invite criticism and create revulsion toward you.

Public relations has changed, yes, but the principle remains the same. In this modern era the need for thoughtful consideration of the patient is as great as in 1882.

The horse and buggy age that gave time for the development of deep personal and professional relationships has given place to an age of speed and technological advances, giving rise to a casual and somewhat shallow relationship.

With the development of this casual and less awed attitude of the public towards the physician has come a weakened respect for the physician. Unfortunately, this attitude also has been applied by the public to those physicians who are sound and to those who have given their lives to serving the public. Medicine, of course, must defend itself against attacks, but it also must continually search for improved methods of serving the public. Through satisfactory public relations comes mutual respect, harmony, good will, and understanding.

A few years ago, we switched our public relations emphasis from a short term campaign to a long range program. If we were to be successful, it was necessary that the medical profession make every effort to straighten its halo. We had some fence mending to do and have proceeded with reasonable success.

OPINION SURVEY

General comments on the public relations of the medical profession have not been good. After five years of increased public service on the part of our county and state medical societies, we are reluctant to accept such broad accusations without substantial proof. Consequently, there have been several public opinion surveys to collect the facts.

The following are tabulated answers to questions used in a survey of public opinion in Los Angeles:[1]

What do the following words mean to you?

85 per cent gave incorrect answers to the word internist.
70 per cent were incorrect on oculist.
86 per cent were incorrect on ophthalmologist.
77 per cent were incorrect on osteopath.

Can you identify the following symbols?

58 per cent missed D.O.
55 per cent missed D.C.
8.9 per cent missed M.D.

Have you ever changed doctors in the Los Angeles area?

54 per cent replied that they had for the following reasons:
Not a specialist—10.14 per cent.
Charged too much—10.7 per cent.
Not thorough—17.7 per cent.
Would not make night calls—7.7 per cent.

If you were to go to a doctor's office 10 times, about how many times out of 10 would you say the doctor would keep you waiting?

10 out of 10 times—18 per cent.
9 out of 10—15 per cent.
5 out of 10—12.8 per cent.
2 out of 10—10.3 per cent.

Is this reasonable?

Yes—82 per cent.
No—10.5 per cent.

Does the average doctor earn too much?

Yes—17 per cent.
About right—63 per cent.
Too little—7.3 per cent.

To summarize some of the other findings: Only 11 per cent felt they couldn't get a doctor at night or on Sundays; 86.8 per cent had heard of the Los Angeles County Society; 69.7 per cent had heard of the California Medical Association; and 86.8 per cent had heard of the American Medical Association.

Seventy per cent wanted bills itemized; 78 per cent wanted a letter of notification after 30 days; 50 per cent felt that the bill should be turned over to a collection agency after a reasonable length of time; 86 per cent had no complaints about the doctor or his office; 34 per cent thought hospital bills reasonable and 74 per cent unreasonable because 64 per cent couldn't afford it. The last time they went to a doctor, 88 per cent thought his fee was reasonable; but when asked about fees in general only 60 per cent thought them reasonable.

From these responses, I would say that the medical profession is not the big bad wolf, the selfish, inhuman group that it has been accused of being. But that does not mean that we should be content and make no effort to meet the criticisms voiced. Sound research scientists warn that any negative percentage which exceeds 10 per cent is an indication that something needs to be done.

IMPROVING PUBLIC RELATIONS

There are some who feel that good public relations can accomplish miracles. And so it can if the program is sound and if all are willing to participate. Here lies the greatest weakness of medicine's public relations. Your own survey in Texas[2] revealed that attendance at county medical society meetings ranged from 71 per cent in the small society to 15 per cent in the society with more than 200 members. The report also stated that in the small society, 8 per cent of the members were considered deadwood and 30 per cent were deadwood in the large society of more than 200 members.

With medicine's public relations so dependent upon the public relations of each individual physician and his participation in county society public relations projects, we must admit that there are limita-

rions to the effectiveness of our program. If only half of our team is playing, then efforts must be exerted to enlist the support of the other half.

One always should try to make a distinction between poor public relations and honest difference of opinion.

I can appreciate the public relations concern of some of our members when attacks are made upon the medical profession, but when these attacks are based on policy, the profession must take them in stride, with a full sense of satisfaction that the policy is sound and that it is the profession's duty to express itself on all measures affecting the health and welfare of the American people.

Whenever the AMA abandons principle for the lure of the popularity poll, it will have abdicated its position of trust, responsibility, and leadership in the medical affairs of the nation.

Another major factor to be considered in evaluating medicine's public relations program is the evolutionary change which is taking place in the physician-patient relationship. Improved communications, the rising educational level of our population, the advent of new and improved mechanical diagnostic devices, the success of antibiotic therapy, and the demands for medical care on the basis of prepayment coverage are all contributing factors in the changing attitude of the general public toward physicians.

Public relations embodies every activity of your society and its individual members.

Unfortunately, the term itself is often misused, misinterpreted, and misunderstood. Too often we have developed our society programs in the name of public relations and requested increased budgets because these expenditures are necessary to better our public relations.

This is the wrong approach in my opinion. Our programs should be developed in the name of improved services to the general public and the individual patient, the results of which may then be properly classified as good public relations.

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♦ Mr. Brown, 535 North Dearborn, Chicago 10.

Annual Session
Galveston
April 21-25

Press Relations

JOHN L. BACH

Chicago, Illinois

THERE are some people who are quick to make the broad statement that the medical profession's public relations is bad.

I do not believe this statement is true; in fact, just the opposite is true. The medical profession's public relations is better than that of any other profession.

As a profession, the doctor is in a class by himself because he is the only person who deals with life; therefore he is the most vulnerable to attack. His public relations, for good or bad, is at stake from the

JOHN L. BACH, *Director of Press Relations, American Medical Association, was a special guest speaker at the Texas Medical Association's Public Relations Conference in Austin, September 10, 1955.*

time he gets up in the morning until he goes to bed at night. Nearly every decision he makes carries, in a sense, an element of hazard. Everything the doctor does has a potential for good or harm to the patient. That can hardly be said for any other profession.

MEDICINE IN MASS MEDIA

Newspapers and magazines are publishing more and more medical science news.

An average of 23 lengthy medical stories are appearing in the mass publications—those with a circulation of more than a million—every month.

The National Association of Science Writers, representing the "cream of the crop" in the medical science writing field today, now has more than 200 members. Most of them are full-time writers and many specialize in writing medical science exclusively.

Dan Mich, editorial director of *Look* magazine, recently released figures showing the tremendous increase during the past 30 years in the amount of space devoted by popular magazines to medical subjects. His research department checked articles published in all American magazines in 1923 on just four medical subjects—cancer, tuberculosis, heart disease, and poliomyelitis. There were a total of 30 in 1923, and 19 of these were on tuberculosis. None were in any magazines which today could be de-

scribed as a mass circulation medium. In 1953 there were 299 articles on the same four subjects in popular magazines, most of them big circulation magazines.

Many metropolitan newspapers have their own science writers. The late Howard Blakeslee of the Associated Press once made a survey of Associated Press member papers and found that medical science stories rated first in reader interest, exceeding even sports. This gives a good idea of the live interest in medical science news.

According to popular science writer Steve Spencer of *The Saturday Evening Post,* this appetite is traceable to two main urges of the human mind, the urge to live and the urge to know.

As one patient wrote to a doctor far away from his home, "I am sick and you are a specialist in the disease I am suffering from. I do not like to bother you, but your information is important to me. You see, I am interested in living."

These motivations on the part of the public create a greater demand for the doctor's services and, at the same time, a greater demand for the science writers' product.

NEED FOR PUBLIC KNOWLEDGE

But all this medical publicity, much of it sparkling with glamour, is beginning to carry a boomerang. The publicity has built up in the public mind a high regard of medical science.

Today the word "science" has some of the connotations of magic in the nonscientific man's vocabulary. "Science reveals" a new substance to make teeth whiter, a way to estimate a person's fitness for a job, or a chance to cruise around the solar system. It is not easy for the man in the street to understand where science leaves off and science fiction begins. His science fiction expectations are becoming attached to his doctor who is the only real live scientist he knows—a dispenser of wonder drugs and a performer of lifesaving operations.

The doctor may have a hard time adjusting to this sphere. It creates conflicts in his attitude toward his practice and in his relationships with his patients. He thinks that to keep his patients' confidence he must live up to a superhuman role and build the illusion that medicine is an exact science and doctors are infallible. Yet if the medical profession officially or the individual doctor promotes illusion, he is immediately involved in a complex of problems. He is placing himself in a vulnerable position, because he cannot deliver the goods.

Our job in medicine is to create a better understanding of the physician's duties, his capacities and limitations, and what may reasonably be expected of him.

The doctor who says "If you tell them you don't know, they lose faith in you" is not looking far enough ahead. He forgets that if you don't tell them and they find out, they not only lose faith; they are disillusioned and even vindictive. Magazine editors whose business it is to gauge public response and thereby build circulation will not hesitate to exploit this bitterness, until the practicing physician may never know, when he approaches a treatment room door, whether the patient on the other side thinks the doctor is a god or a crook. The good doctor does not want to be either.

So much has been published in the press about scientific advances in medicine that it has led many people to expect all sorts of spectacular results which are not borne out by experience. Perhaps organized medicine should begin to emphasize this fact. Perhaps the official attitude of organized medicine should be patterned on something more nearly like the classic humility of the old country doctor, who often said: "I have done all I can; we must leave the rest to God."

DOCTORS ARE HUMANS

The time has come when we in medical public relations must eulogize the American doctor as a human being. Parke, Davis & Company has been doing this for 22 years with a series of fine advertisements entitled "See Your Doctor." The Key Corporation, a small Miami pharmaceutical firm, is doing this in a limited way with a series of advertisements entitled "The American Doctor—The Man Is Greater Than the Myth."

Folklore penalizes today's doctor. It obscures the basic fact that the doctor is mortal; that he is a man who must earn his daily bread.

We must shout from the roof tops the astounding figures which total up the hours doctors spend in clinics, hospitals, on calls, for which they receive no payment or expect any. The doctor deserves no medal for this. But these unpaid bills and freely given hours can add up to lost income.

Dr. James D. Tyner, Newark, N. Y., once told a New York State Medical Society public relations conference that the average doctor spends 12 per cent of his working hours doing charity work. He added that the dollar value of the time given to charity patients by the average physician is more than $3,000 annually and his donation of time from 1947 to 1951 increased 15 per cent.

How does this match with the accepted business practices in other fields? Do bankers offer their specialized knowledge and time without expectation of

payment? Do lawyers? Brokers? Accountants? You don't expect them to, and furthermore you would think a business man foolish who did not seek every profit to which he is entitled. The doctor cannot. There is his legend to be appeased.

He must, through good relations with the public and the press, teach the differences between himself and his legend. And all the while, he must keep his patients' confidence, the public's good will, and his own self-respect.

Mr. Bach, 535 North Dearborn, Chicago 10.

PR Programing For County Societies

J. M. COLEMAN, M. D.

Austin, Texas

IN DISCUSSING a public relations program for county medical societies, I must disclaim any expertness in the field of public relations. My only qualification is that I have served as president of a society that has carried on a program during the last year. I feel that my best contribution can be a simple discussion of those factors which have seemed to be most important.

First, a public relations program must do something for the people. It must be more than a public relation of the virtues of medicine and medical men. You and the committee that you select must be sure that you truly believe that the future of medicine and the medical profession is dependent upon the development of a positive program and an attitude of respect engendered thereby. Your society must be willing to forego petty jealousies, or if this is asking too much, your committee must have the integrity to go ahead and "damn the torpedoes." Names and pictures inevitably will appear and the committee must accept responsibility for these.

Public relations is not a new thing in medicine. For an example of an excellent public relations action, I refer you to an Austin newspaper of February 11, 1874. This item reads:

> At a regular meeting of the Travis County Medical Society on the 9th instant, several cases of trichinosis were brought before the Society by Dr. B. Hadra. The disease is caused by eating pork similarly affected and is one involving the welfare of the community. It is due to a small animalicule that is destroyed by high temperatures. Consequently as much suffering and death may be avoided, we recommend that all pork for table use be thoroughly cooked. Signed, J. M. Litten, president; J. Cummings, secretary."

This item appealed to me because it did something for the people and because there was no holding back of names.

Several advantages existed in our society when we began our public relations program. We had had a preliminary society interest stirred up by a public relations committee for two years, and many of the men were thinking in these terms. A grievance committee and an emergency panel were already functioning, and another asset was a budget. We had set aside a part of the dues of the society, and since no projects had been attempted these had accumulated. Programs do not need to be particularly expensive but some available fund is helpful. Probably nothing is so important as the selection of a chairman who has demonstrated by speech and action an interest in public esteem for physicians. We enlarged our public relations committee, which had formerly been three in number; we made it six, and next year we will make it nine. We feel that as many members as possible should be involved.

Once a committee has been selected, it becomes important to find a theme. We believe that the public relations programs must be more than a show. There must be some center of interest around which a message can be built. Ours seemed best tied to the fact that our society was 101 years old. No birthday had ever been celebrated and so in commemoration of this event, we called our theme "The Beginning of a New Century of Medicine in Austin." There could be many themes; for example, with interest in immunization, we might note that Pasteur gave his first treatment in 1885. This, therefore, marks 70 years of progress in immunization. In 1796, Jenner gave the smallpox vaccination to the first human being; therefore, next year we could point to the pageant of progress in 160 years of immunization.

TRAVIS COUNTY ACTIVITIES

Specifically, the items of our anniversary celebration consisted first of a special Sunday newspaper supplement. This was 24 pages, and many members of the society contributed information. We did some historical research and had several interesting discoveries which had not been noted previously. This spe-

Presented at the Texas Medical Association's Public Relations Conference in Austin, September 10, 1955.

cial supplement pointed to advances in medicine and directed attention to our second effort, an open house to be held at the Texas Medical Association building.

This open house was in the form of a health fair with about 30 exhibits of progress in medicine. We found a capable chairman, and he drew exhibits from the American Medical Association, the American Cancer Society, the Tuberculosis Association, the Diabetes, Heart, and Cerebral Palsy organizations, the University of Texas, our health departments, and Baylor University College of Medicine, which permitted us to use its award winning exhibit from the AMA meeting in California. It was necessary to select our hosts in an arbitrary manner, so each doctor was advised of a two hour period during the four days when he would be a host at the exhibits. The response by the members of the society was tremendous, and many of them derived sincere pleasure from discussing exhibits with school children or answering questions of visitors. The medical auxiliary aided in the registration of visitors. To encourage registration, a prize of a Blue Cross-Blue Shield policy donated by the society, was given on the last evening. Attendance was numbered in thousands.

On the last night of our open house, we initiated our third movement, our health forum program. The Altrusa Club of Austin was interested in sponsoring such a forum as a public service, and this group of business women proved highly capable in the dissemination of publicity and information about the programs. A box was inserted in the newspaper for questions to be submitted by the public, and there were radio and television programs obtained through the help of the Altrusa Club. During the year, our society gave seven forums in which 38 doctors participated, and the forums played to standing room crowds.

The success of our program in Austin must be attributed in a great measure to our public relations chairman, Dr. Frederick Lowrey, and to the forum chairman, Dr. J. Edward Johnson. These two have submitted a report called "Hindsight Observation on Forum Production and Presentation," and I feel that it is worth while to include it in this symposium:

1. The feeling is that the forum time should be limited to one hour mandatorily. An additional period for surplus questions after a five minute break should not exceed 15 minutes.

2. Questions from the floor must never be accepted. These were the items which caused problems.

3. There were some faults in our presentation; some were too stiff and formal, some too chatty and informal. The movement of the discussion as well as the manner of the speakers was sometimes too deliberate and time consuming and too much time on occasion was wasted in the extra period and the audience became tired out.

4. Coaching responsibilities and problems. The forum committee needs to supervise the outline in the preparation in each forum discussion and should attend at least the first three practice sessions and the full dress rehearsal the evening before the presentation. Orientation of forum members to their responsibility should be first on the committee's agenda. Our committee felt that the main reason a few of our speakers did not measure up to the level of excellence expected was because of our failure to impress them with the necessity of hard work and devotion that is indispensable for the best performance. Speakers should learn their discussions so well that they can give them without reference to manuscript.

Production Experience: It is very desirable that a newspaper sponsor the forum but whether it does or does not, members of the society must assist in writing and transmitting six or seven stories to the newspaper in advance of a forum. They must pick up the questions sent to the forum editor, must arrange for pictures of the panel members, and should take notes of the forum and call the night editor so that the discussion appears in his story for the next day. It is important that the hall be secured in advance of each forum so that no slip-up occurs. The sound equipment man must be notified to be available for both rehearsal and presentation, and someone must maintain liaison with the sponsoring agency or organization to see that proper publicity in radio, television, as well as by other means, is secured for each program.

The tangible and intangible values derived from the health forums might be listed as: (1) The society on parade. The members of the forum panels had the feeling that for one night they were the medical society and as such they were on the stage in the limelight in the view of the public who had come out to see what we are like as a profession. (2) The "let's understand each other" attitude. The preparation for a forum requires first of all, study of the average patient's attitude and his information or lack of it, his misunderstandings, his failures to take advantage of medical services available to him, and the shortcomings of the profession in meeting the needs. (3) The language barrier. One of the most frequent criticisms thrown at doctors is that he "never takes time to talk to me" or "uses words that are too big." Our panel members found the translation of their customary scientific discourse into ordinary backyard English to be one of the hardest requirements of forum presentation. The committee feels that every member of the county medical society should have this opportunity to learn to converse with his patients in a language that they can understand. (4) The homework assignment. The homework required of each panel member for discussion of the subject continued to amaze the committee as we followed each group through preparation for forum discussions. Each question received must have an adequate and correct answer. This means that the information given must reflect current medical opinion, or the speaker must give an explanation of his reasons for its divergencies. When two or more theories or opinions currently are held by the profession, both views must be given, although the one preferred by the speaker may be stressed if he so desires.

The committee rates this opportunity to drive home to physicians an awareness of their responsibility to their fellow practitioners and the profession as a whole, as well as the public, as one of the most important values physicians derive from the forum experience.

The emergency call panel is part of PR programing; ours already existed and of course has problems. It still is a voluntary emergency call panel. No physician is required to sign up to serve, but on any given day there is a first, second, and third call physician

available. Probably as many problems arise from misuse of this service by physicians who are unwilling to take care of their patients as from unnecessary calls by patients.

OTHER PROJECTS

There are many other public service projects which may be tried by a society. We have considered using the welcome wagon, which meets all new comers to the community, as a possible source of disseminating information about the society, the hospitals, and the emergency panel system. Our society maintains an emergency center with a doctor on duty at the University of Texas football games, and since this provides him with a ticket he seems to appreciate the opportunity to serve.

One type of program which seems to have some possibility is the vocational guidance day which is becoming popular in our public schools. Representatives of various businesses and professional groups appear in the schools to describe the type of activity and the future within their field. We feel that members of the medical profession might use this for better understanding of our services and of our background.

Surveys of community needs demonstrate the interest of the medical profession in the community and all of its people, and usually will reflect with advantage. Among the types of programs which have been successful, which we contemplate, is a survey of accidents with possible development of some sort of information for the public which will direct attention to the prevention of accidents. Maternal and infant mortality studies and surveys have been of importance.

The Salk vaccine immunization program caused problems in many communities, and it was due to the work of our chairman in Travis County that our program seemed to work successfully. Our chairman was alert to the development of the inoculation program, and he was able to step in at the first moment and direct the complete organization of the whole program. He advised all of those concerned that as a society we did not approve of the mass immunization program, but that because the National Foundation for Infantile Paralysis had purchased vaccine for the specified group in school and in order to disseminate the vaccine as widely as possible as a public service, we would participate. Working with the nursing profession, with the teachers, and with the parent-teacher groups, our chairman was able to set up a program which produced the least amount of disturbance of the time of the doctor and yet produced an eminently satisfactory program to all that participated in it. This was an effective public relations activity.

In addition to the previously listed activities, the society also initiated a television program of one-half hour monthly. In addition to the group that had served in the forum, another 20 to 30 doctors participated in these programs.

We feel that the Travis County Medical Society's public relations program for 1955 was a success. Its success was possible only through the hearty cooperation of all members of the society, the willingness of physicians to serve the community wherever a need existed, and active committees which were alert and responsive to the problems which exist.

♦ Dr. Coleman, Children's Medical Center, 108 West 30, Austin.

The Grievance Committee as A Function Of the County Medical Society

SYLVESTER W. THORN, M. D.

Houston, Texas

WITHIN the past several years the medical profession has become increasingly aware of the importance of good public relations. Articles appearing in lay journals caused the thinking members of the profession to realize that there was a marked undercurrent of dissatisfaction with doctors' services, their charges, or some other aspect of medical care and that the confidence of the public in our system of practice was being undermined. In his presidential address before the Southern Medical Association in 1950, Dr. Hamilton W. McKay commented upon the situation, stating, "Something is radically wrong between the medical profession and the people of America. There is a gulf deep and wide between the

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doctor and his potential patients. . . . He simply does not know that it is not enough to do a good scientific job, he is a bungling novice in the art of human relationships."

Finally, the profession, through its national, state, and local organizations, took cognizance of this state of affairs and set about to correct it by establishing public relations committees. These committees spent much time and effort in analyzing the reasons for the disruption of the rapport between the profession and the public. Out of the maze of this inquiry, one fact was shown above all others, that is, that good public relations depends upon the public relations of the individual physician in his daily contacts with his patients, friends, and business associates. Just as it is true that the whole is but the sum of its parts, it is true that the public relations of a group is but the sum of the public relations of its individual members.

One who accepts the privilege of practicing medicine must also, as an individual, assume the obligation "to uphold the dignity and honor of his vocation." Although most doctors are honest and conscientious in the discharge of this obligation, there are a few who exploit those who come to them seeking aid and counsel. There is also the occasional serious offender whose activities threaten the health and even the lives of his patients.

The public grievance committee is the medical profession's means of dealing with both the marginal and serious offender in a self-disciplinary manner. Until this program was instituted, patients who felt they had not been properly dealt with by doctors had no means of presenting their complaints to the profession. Only an occasional committee had been created for this purpose. The first probably was a committee on ethics and discipline which was established 80 years ago by the Massachusetts Medical Society and which is still functioning. The Minnesota State Medical Association established such a group in 1936, but not until 1947, when the Colorado State Medical Society formed a grievance committee and urged the public to take advantage of its services, did the idea begin to spread. In 1949, the Oklahoma State Medical Association established a state grievance committee, which met with an instant and enthusiastic reception by both the lay public and the press and resulted in an immediate improvement in public relations between the Oklahoma doctors and their patients. After investigating the effectiveness of the Colorado and Oklahoma grievance committees, the American Medical Association officially approved the movement in 1949 and urged the state societies to establish such committees to hear and settle complaints. At the present time, there are active grievance committees in all 48 states and in 800 component county societies. These committees provide fair hearings for both patients and physicians whenever they are unable to settle their disagreements between themselves.

ORGANIZATION AND RESPONSIBILITY

A grievance committee is, by my definition, the committee of the state or county medical society which receives and investigates complaints from any source involving the ethics and conduct of the medical practice of the members of the society. It hears all witnesses to the complaint as appears appropriate and, if necessary, refers the matter to the board of censors for action. Its members should be men of unquestionable personal integrity who command the respect and confidence of the public as well as of their colleagues.

The number of members of these committees usually varies from two to ten. Our Harris County grievance committee has nine members. They are chosen from most of the medical specialties, including general practice. By this selection of men who are conversant with the problems of practice in the various fields of medicine, the validity of each complaint and the propriety of the treatment rendered by the defendant physician can be more fairly determined. Not only does the division of specialty interest enable the committee to make a more logical and equitable decision in each case, but the explanation of the point in question is more readily accepted by the complainant if he knows he is receiving the opinion of a physician who is an authority in his particular field. When a complaint lies within the province of a specialty not represented by a committee member, a group of two or more physicians qualified in that specialty are asked to assist the committee in an advisory capacity. The Harris County Medical Society grievance committee not infrequently resorts to this expedient.

The types of complaints heard by the grievance committee vary widely. The 69 complaints which have been handled by our committee since its inception in 1953 were distributed as shown in table 1.

It will be observed that none of these complaints concerned a fee. Contrary to the custom in many county medical societies, in the Harris County Medical Society the adjudication of fees is delegated to a separate committee appointed to perform this function. On many occasions, however, we have found that the adjudication of fees is directly related to the ethics and conduct of the physician in question. In such cases, the problem of fees is considered secondary; consequently, it has been our policy to handle complaints of this nature through the grievance committee.

From a public relations standpoint, the greatest good is accomplished by resolution of the grievance within the committee. Many complaints brought by patients stem from misunderstandings which arise when a physician neglects to explain fully in advance the type of treatment required or the cost of the medical service rendered. Settlement of such complaints is usually possible by an explanation of the problem to the complainant and, if indicated, an apology by one or both parties. Fortunately, most of the complaints referred to our committee, even those which were potentially dynamite, have been settled to the satisfaction of all concerned.

TABLE 1.—*Types of 69 Complaints Handled by Harris County Medical Society Grievance Committee, 1953-1955.*

Complaint	No.
Improper medical treatment	21
Improper surgery	10
Failure to make calls	6
Failure to make correct diagnosis	6
Narcotics addiction	5
Unprofessional attitude	4
Failure to name substitute	3
Adverse publicity	3
Refusal to accept emergency patient	2
Fraudulent insurance report	2
Delegation of treatment	2
Poor surgical result	2
Failure to examine properly	1
Abandonment of patient	1
Death due to negligence	1

In the course of our two and one-half years in operation we have found that the vast majority of grievances were initiated by some casual remark by a fellow physician who was unfamiliar with all the facts. We do not believe it is necessary for physicians to advise patients to make complaints, or to comment about another physician's competence in such a manner as to plant the seeds of doubt in the patient's mind.

Doctors occupy a unique position in their communities. By tradition, in the mind of the public, they wear a cloak of infallibility. Whereas the attorney, the accountant, the engineer, or the master plumber is permitted an occasional human error, the doctor who errs is damned. Since physicians are no more infallible than other human beings, it is as much a function of the grievance committee to protect the honest, painstaking practitioner from unjustifiable criticism as to prosecute those guilty of malfeasance. On the other hand, the committee members should make it clear to the complainant that it is their duty to make impartial decisions and not to "whitewash" the medical profession. As proof of its impartial attitude, during the 30 months of its existence, the Harris County Medical Society grievance committee has referred eight doctors to the board of censors for disciplinary action.

PROCEDURE

In conducting its inquiries, our grievance committee observes a more or less regular routine, as follows:

1. Consideration is given only to signed written complaints referred by individuals who believe that they have been unjustly treated by a doctor. In addition to this function, the Harris County grievance committee has the power to initiate the investigation of any suspected breach of moral or medical ethics that may be brought to its attention from any source —adverse newspaper publicity, hospital committees or individual physicians, and laymen. Our grievance committee has utilized this prerogative on two occasions during the past 30 months. In one instance, our investigation resulted in the voluntary retirement from practice of the defendant doctor until he was completely rehabilitated.

2. After the complaint is received, the complainant is invited to appear before the committee and elaborate upon his complaint if he desires. Often, additional information is brought out by such an interview.

3. When appropriate, affidavits properly signed and witnessed are obtained from material witnesses. Subcommittees are appointed to carry out this function.

4. The complainant is required to give the grievance committee written permission to examine hospital and other records pertinent to the case.

5. When the agenda is overcrowded and consideration of a complaint will be delayed, a letter of acknowledgment and explanation is sent to the complainant so he will not feel that the matter has been ignored.

6. After the complainant has been interviewed, other witnesses, both material and expert, may be asked to appear.

7. Following completion of the preliminary investigation, the defendant physician is notified of a complaint and requested to appear before the committee, bringing all the material in his possession pertaining to the case in question.

8. After all the testimony has been presented and weighed, a decision regarding the disposition of the problem is reached by majority vote of the committee.

9. Both the complainant and defendant physician are notified in writing of the decision of the committee.

10. Those cases in which disciplinary action is required are referred to the board of censors. Thus far, not a single case handled by our committee has been appealed to a higher level, although such an avenue of appeal is open to the physician.

CONCLUSION

The purpose of this paper has been twofold: first, to describe the functions of the grievance committee and, second, to point out that in the final analysis good public relations depends upon the individual physician.

So it is with our public relations. If each physician maintains good public relations in his community; if he deals honestly and conscientiously with his patients and, in fact, conducts his entire life in a manner which inspires the loyalty, admiration, and respect not only of his patients, but of all his associates, it will be unnecessary for medical organizations to convince the public that we are good doctors. Public relations, like charity, should begin at home.

Dr. Thorn, 1406 Hermann Professional Building, Houston.

★ Coming Meetings

Texas Medical Association, Galveston, April 21-25, 1956. Dr. J. Layton Cochran, San Antonio, Pres.; Mr. C. Lincoln Williston, 1801 North Lamar Blvd., Austin, Executive Secy.

American Medical Association, Clinical Meeting, Boston, Nov. 29-Dec. 2, 1955. Dr. Elmer Hess, Erie, Pa., Pres.; Dr. George F. Lull, 535 North Dearborn, Chicago 10, Secy.

National and Regional

American Academy of Allergy, St. Louis, Feb. 6-8, 1956. Dr. Stanley F. Hampton, St. Louis, Pres.; Dr. Frances C. Lowell, 65 E. Newton, Boston, Secy.

American Academy of Dermatology and Syphilology. Dr. Arthur C. Curtis, Ann Arbor, Pres.; Dr. James R. Webster, 55 E. Washington, Chicago 2, Secy.

American Academy of General Practice, Washington, D. C., March 18-23, 1956. Dr. John R. Fowler, Barre, Mass., Pres.; Mr. Mac F. Cahal, 406 W. 34th St., Kansas City 2, Executive Secy.

American Academy of Obstetrics and Gynecology. Dr. William F. Mengert, Dallas, Pres.; Dr. C. Paul Hodgkinson, 116 S. Michigan Blvd., Chicago 3, Secy.

American Academy of Ophthalmology and Otolaryngology. Dr. Algernon B. Reese, New York, Pres.; Dr. W. L. Benedict, 100 First Ave. Bldg., Rochester, Minn., Secy.

American Academy of Pediatrics, New York, Oct. 8-11, 1956. Dr. Harry Bawkin, New York, Pres.; Dr. E. H. Christopherson, 610 Church, Evanston, Ill., Secy.

American Association for Thoracic Surgery, Miami Beach, Fla., May 7-9, 1956. Dr. Richard H. Meade, Grand Rapids, Mich., Pres.; Dr. Paul C. Samson, 3959 Happy Valley Rd., Lafayette, Calif., Secy.

American Association of Genito-Urinary Surgeons, Oyster Harbors, Mass., June 4-6, 1956. Dr. Norris J. Heckel, Chicago, Pres.; Dr. John A. Taylor, 2 E. 45th St., New York 22, Secy.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons. Dr. Thaddeus L. Montgomery, Philadelphia, Pres.; Dr. F. R. Lock, Bowman Gray School, Winston-Salem, N. C., Secy.

American Cancer Society. Dr. Guy Aud, Louisville, Ky., Pres.; Mr. M. R. Runyon, 47 Beaver, New York, Executive Vice-Pres.

American College of Allergists, New York, April 15-20, 1956. Dr. Lawrence J. Halpin, Cedar Rapids, Iowa, Pres.; Dr. Fred W. Wittich, 401 La Salle Medical Bldg., Minneapolis 2, Secy.

American College of Chest Physicians, Chicago, June 7-10, 1956. Dr. James H. Stygall, Indianapolis, Pres.; Mr. Murray Kornfeld, 112 E. Chestnut, Chicago 11, Executive Secy.

American College of Physicians, Los Angeles, April 16-20, 1956. Dr. George F. Strong, Vancouver 1, B. C., Pres.; Mr. E. R. Loveland, 4200 Pine, Philadelphia 4, Secy.

American College of Radiology, Chicago, Feb. 10-11, 1956. Dr. Warren W. Furey, Chicago, Pres.; Mr. W. C. Stronach, 20 N. Wacker Dr., Chicago 6, Executive Secy.

American College of Surgeons. Dr. Alfred Blalock, Baltimore, Pres.; Dr. Michael L. Mason, 40 E. Erie, Chicago 11, Secy.

American Congress on Obstetrics and Gynecology. Dr. R. Gordon Douglas, 116 S. Michigan Ave., Chicago 3, Chm.

American Congress of Physical Medicine and Rehabilitation, Atlantic City, N. J., Sept. 10-14, 1956. Dr. Gordon M. Martin, Rochester, Minn., Pres.; Dr. Frances Baker, 1 Tilton Ave., San Mateo, Calif., Secy.

American Dermatological Association, Santa Barbara, Calif., June 18-21, 1956. Dr. V. Pardo-Castello, Havana, Cuba, Pres.; Dr. J. Lamar Callaway, Duke Hospital, Durham, N. C., Secy.

American Gastro-Enterological Association, Atlantic City, N. J., April 27-28, 1956. Dr. Robert Elman, St. Louis, Pres.; Dr. H. Marvin Pollard, University Hospital, Ann Arbor, Mich., Secy.

American Gynecological Society, Washington, D. C., May 21-23, 1956. Dr. Isidor C. Rubin, New York, Pres.; Dr. John I. Brewer, 104 S. Michigan Ave., Chicago, Secy.

American Heart Association. Dr. E. Cowles Andrus, Baltimore, Pres.; Mr. Irving Hexter, 44 E. 23rd, New York 10, Secy.

American Hospital Association, Chicago, Sept. 17-20, 1956. Mr. Ray E. Brown, Chicago, Pres.; Dr. Edwin L. Crosby, 18 E. Division, Chicago, Executive Director.

American Laryngological, Rhinological, and Otological Society, Montreal, Canada, May 15-17, 1956. Dr. Dean M. Lierle, Iowa City, Pres.; Dr. C. S. Nash, 277 Alexander, Rochester 7, N. Y., Secy.

American Neurological Association, Atlantic City, N. J., June 18-20, 1956. Dr. J. M. Neilson, Los Angeles, Pres.; Dr. Charles Rupp, 133 S. 36th, Philadelphia 4, Secy.

American Ophthalmological Society, Hot Springs, Va., May 31-June 2, 1956. Dr. Alan C. Woods, Baltimore, Pres.; Dr. M. C. Wheeler, 30 W. 59th, New York 19, Secy.

American Orthopedic Association, Banff, Canada, June 20-23, 1956. Dr. Paul C. Colonna, Philadelphia 4, Pres.; Dr. George O. Eaton, 4 E. Madison, Baltimore 2, Secy.

American Pediatric Society, Buck Hill Falls, Pa., May 6-11, 1956. Dr. Allan M. Butler, Boston, Pres.; Dr. A. C. McGuinness, 237 Medical Laboratory, University of Pennsylvania, Philadelphia 46, Secy.

American Proctologic Society, Detroit, June 6-9, 1956. Dr. Stuart T. Ross, Hempstead, N. Y., Pres.; Dr. Karl Zimmerman, 3500 Fifth Ave., Pittsburgh 13, Secy.

American Psychiatric Association, Chicago, April 30-May 4, 1956. Dr. R. Finley Gayle, Richmond, Va., Pres.; Dr. William Malamud, 80 E. Concord, Boston 18, Secy.

American Public Health Association, Atlantic City, Nov. 12-16, 1956. Dr. Ira V. Hiscock, New Haven, Conn., Pres.; Dr. R. M. Atwater, 1790 Broadway, New York 19, Executive Secy.

American Society of Anesthesiologists, Kansas City, Mo., Oct. 8-12, 1956. Dr. Scott M. Smith, Salt Lake City, Utah, Pres.; Dr. J. E. Remlinger, Jr., 188 W. Randolph, Chicago, Secy.

American Society of Clinical Pathologists, Chicago, Oct. 7-12, 1956. Dr. Emma S. Moss, New Orleans, Pres.; Dr. Clyde G. Culbertson, 1040 W. Michigan, Indianapolis 6, Secy.

American Surgical Association, W. Sulphur Springs, W. Va., April 11-13, 1956. Dr. Alfred Blalock, Baltimore, Pres.; Dr. R. Kennedy Gilchrist, 59 East Madison, Chicago 3, Secy.

American Urological Association, Boston, May 28-31, 1956. Dr. George C. Prather, Brookline, Pres.; Dr. Samuel L. Raines, 188 S. Bellevue Blvd., Memphis, Tenn., Secy.

Association of American Physicians and Surgeons, Annual Meeting, Columbus, Ohio, April 5-7, 1956. Dr. James L. Doenges, Anderson, Ind., Pres.; Mr. Harry E. Northam, 185 N. Wabash Ave., Chicago 1, Executive Secy.

International College of Surgeons, U. S. Chapter. Dr. Arnold S. Jackson, Madison, Wisc., Pres.; Dr. Karl Meyer, 1516 Lake Shore Dr., Chicago, Secy.

National Tuberculosis Association, New York, May 21-25, 1956. Dr. Edward T. Fagan, Brooklyn, Pres.; Mrs. Morrell DeReign, 1790 Broadway, New York 19, Secy.

Radiological Society of North America. Dr. Tom B. Bond, Fort Worth, Pres.; Dr. D. S. Childs, 713 E. Genesee, Syracuse 2, N. Y., Secy.

Southern Medical Association, Washington, D. C., Nov. 12-15, 1956. Dr. Raymond McKenzie, Baltimore, Pres.; Mr. V. O. Foster, 1020 Empire Bldg., Birmingham 3, Secy.

Southern Psychiatric Association. Dr. John D. Trawick, Louisville, Pres.; Dr. Joseph L. Knapp, 210 N. Westmoreland, Dallas, Secy.

Southern Surgical Association. Dr. Carrington Williams, Richmond, Pres.; Dr. George Finney, 2947 St. Paul, Baltimore, Secy.

Southwest Allergy Forum. Dr. Henry D. Ogden, New Orleans, Pres.; Dr. Stanley Cohen, 1441 Delachaise, New Orleans, Secy.

Southwest Regional Cancer Conference. Dr. John L. Wallace, Box 1719, Fort Worth, Chm.

Southwestern Medical Association. Dr. Joseph Bank, Phoenix, Pres.; Dr. Celso C. Stapp, 800 Montana, El Paso, Secy.

Southwestern Surgical Congress, Tucson, Ariz., April 16-18, 1956. Dr. C. R. Rountree, Oklahoma City, Pres.; Dr. C. M. O'Leary, 207 Plaza Court Bldg., Oklahoma City, Secy.

Tri-State Medical Society. Dr. William B. Harrell, Texarkana, Pres.; Dr. Karlton Kemp, 408 Hazel, Texarkana, Ark., Secy.

United States-Mexico Border Public Health Association. Mr. Richard F. Poston, San Francisco, Pres.; Dr. Sidney B. Clark, 314 U. S. Court House, El Paso, Secy.

State

Private Clinics and Hospitals Association of Texas, Dallas, December, 1956. Dr. J. P. Anderson, Brady, Pres.; Mr. C. H. Rugeley, Wharton, Secy.

Texas Academy of General Practice, Houston, Sept. 16-19, 1956. Dr. J. D. Murphy, Fort Worth, Pres.; Mr. Donald C. Jackson, 308 W. 15th, Austin, Executive Secy.

Texas Academy of Internal Medicine. Dr. W. W. Bondurant, Jr., San Antonio, Pres.; Dr. George M. Jones, 1314 Medical Arts Bldg., Dallas, Secy. Meetings restricted to members.

Texas Air-Medics Association, Galveston, April 22-23, 1956. Dr. W. A. Ostendorf, Fort Worth, Pres.; Dr. C. F. Miller, P. O. Box 1338, Waco, Secy.

Texas Association of Blood Banks. Dr. O. J. Wollenman, Jr., Fort Worth, Pres.; Miss Marjorie Saunders, 3500 Gaston Ave., Dallas, Secy.

Texas Association of Obstetricians and Gynecologists, Dallas, Feb. 18, 1956. Dr. John Delany, Galveston, Pres.; Dr. Oran V. Prejean, 4317 Oak Lawn. Dallas, Secy.

Texas Chapter, American College of Chest Physicians, Galveston, April 22, 1956. Dr. Samuel Topperman, Tyler, Pres.; Dr. J. O. Armstrong, 3810 Swiss Ave., Dallas, Secy.

Texas Club of Internists. Dr. Charles Barrier, Fort Worth, Pres.; Dr. Charles Darnall, Capital National Bank Bldg., Austin, Secy.

Texas Dermatological Society. Dr. E. B. Ritchie, Galveston, Pres.; Dr. Thomas L. Shields, 1216 Pennsylvania Ave., Fort Worth, Secy.

Texas Diabetes Association, Galveston, April 22, 1956. Dr. Mavis P. Kelsey, Houston, Pres.; Dr. Hugo Engelhardt, P. O. Box 2180, Houston, Secy.

Texas Division, American Cancer Society. Mr. Leonard M. Gunderson, Amarillo, Pres.; Mr. Curt W. Reimann, 1609 Colorado, Austin, Acting Executive Director.

Texas Geriatrics Society. Dr. Donald G. Kilgore, Dallas, Pres.; Dr. J. O. S. Holt, Jr., 3707 Gaston Ave., Dallas, Secy.

Texas Heart Association, Galveston, April 22, 1956. Dr. Kleberg Eckhardt, Corpus Christi, Pres.; Mr. Edgar M. Brown, 404 Jesse H. Jones Library Bldg., Texas Medical Center, Houston 25, Executive Director.

Texas Hospital Association, Dallas, April 3-5, 1956. Mr. Boone Powell, Dallas, Pres.; Mrs. Ruth Barnhart, 2210 Main, Dallas, Secy.

Texas Neuropsychiatric Association, Galveston, April 23, 1956. Dr. Stephen Weisz, Dallas, Pres.; Dr. Bruce H. Beard, 1519 Pennsylvania, Fort Worth, Secy.

Texas Orthopedic Association, Galveston, April 23, 1956. Dr. Paul Williams, Dallas, Pres.; Dr. Margaret Watkins, 3629 Fairmount, Dallas, Secy.

Texas Pediatric Society, Oct. 19-20, 1956. Dr. R. J. Blattner, Houston, Pres.; Dr. James N. Walker, 3616 Tulsa Way, Fort Worth, Secy.

Texas Proctologic Society, Galveston, February 18, 1956. Dr. John McGivney, Galveston, Pres. and Secy.

Texas Public Health Association, Fort Worth, Feb. 26-29, 1956. Mr. Ed Riedel, Austin, Pres.; Mr. H. E. Drumwright, City Health Department, Dallas, Executive Secy.

Texas Radiological Society, Fort Worth, Jan. 20-21, 1956. Dr. Martin Schneider, Galveston, Pres.; Dr. R. P. O'Bannon, 650 Fifth Ave., Fort Worth, Secy.

Texas Railway and Traumatic Surgical Association, Galveston, April 23, 1956. Dr. A. O. Singleton, Jr., Galveston, Pres.; Dr. W. D. Marrs, 306 Broadway, Fort Worth, Secy.

Texas Rheumatism Association. Dr. Charles H. Cornwell, Marlin, Pres.; Dr. Warren W. Moorman, 901 W. Leuda, Fort Worth, Secy.

Texas Society for Mental Health, San Antonio, March 1-3, 1956. Dr. Abe Hauser, Houston, Pres.; Mr. John Lane, 2510 San Antonio, Austin, Acting Executive Secy.

Texas Society of Anesthesiologists, Galveston, April 22, 1956. Dr. Joe B. Wood, Dallas, Pres.; Dr. Milton M. Rosenzweig, 200 Wildwood Dr. E., San Antonio, Secy.

Texas Society of Gastroenterologists and Proctologists, Galveston, April 23, 1956. Dr. W. T. Arnold, Houston, Pres.; Dr. O. P. Griffin, 1101 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Ophthalmology and Otolaryngology, Galveston, 1955. Dr. A. E. Jackson, Fort Worth, Pres.; Dr. Gatlin Mitchell, 1604 Medical Arts Bldg., Fort Worth, Secy.

Texas Society of Pathologists. Dr. C. B. Sanders, Houston, Pres.; Dr. M. H. Grossman, St. Paul Hospital, Dallas, Secy.

Texas Surgical Society, Fort Worth, April 2-3, 1956. Dr. P. I. Nixon, Sr., San Antonio, Pres.; Dr. Albert W. Hartman, 414 Navarro, San Antonio 5, Secy.

Texas Tuberculosis Association, Midland, April 6-7, 1956. Mrs. Joella Terrill Butler, Wichita Falls, Pres.; Miss Pansy Nichols, 2406 Manor Rd., Austin, Executive Secy.

Texas Urological Society, Austin, February 26-27, 1956. Dr. A. J. Ashmore, Corpus Christi, Pres.; Dr. Rex Carter, 1709 San Antonio, Austin, Secy.

District

First District Society, Pecos, Feb. 16, 1956. Dr. Delphin von Briesen, El Paso, Pres.; Dr. W. G. Morrow, Jr., First National Bldg., El Paso, Secy.

Second District Society, Odessa, April 19, 1956. Dr. T. W. Novak, Odessa, Pres.; Dr. Willis T. Carson, 506 North Allegheny, Odessa, Secy.

Third District Society. Dr. M. C. Overton, Jr., Pampa, Pres.; Dr. William Klingensmith, 215 Fisk Bldg., Amarillo, Secy.

Fourth District Society, San Angelo, 1956. Dr. Joe B. Stephens, Bangs, Pres.; Dr. S. H. Martin, 115 S. Park, San Angelo, Secy.

Fifth and Sixth Districts Society, Corpus Christi, July 6-7, 1956. Dr. E. Jackson Giles, Corpus Christi, Pres.; Dr. Maurice Nast, 1126 3rd, Corpus Christi, Secy.

Seventh District Society. Dr. John R. Rainey, Jr., Austin, Pres.; Dr. Leslie C. Colwell, 1410 Brazos. Austin. Secy.

Eighth District Society, Brazoria, 1956. Dr. Carlos Fuste, Alvin, Pres.; Dr. John Childers, Univ. of Texas Medical Branch, Galveston, Secy.

Ninth District Society, Baytown, March 29, 1956. Dr. Joseph T. Dabney, Livingston, Pres.; Dr. Lyman C. Blair, 1212 Rothwell, Houston, Secy.

Tenth District Society. Dr. Taylor Walker, Beaumont, Pres.; Dr. Alan E. Hubner, 590 Center, Beaumont, Secy.

Eleventh District Society. Dr. Porter Bailes, Tyler, Pres.; Dr. Hugh F. Rives, Jacksonville, Secy.

Twelfth District Society, Bryan, January 10, 1956. Dr. Van D. Goodall, Clifton, Pres.; Dr. J. H. Johnson, 304 South 22nd, Temple, Secy.

Thirteenth District Society. Dr. P. M. Kuykendall, Ranger, Pres.; Dr. Robert D. Moreton, 815 Medical Arts Bldg., Fort Worth, Secy.

Fourteenth District Society. Dr. J. David Thomas, Denton, Pres.

Fifteenth District Society, Marshall, 1956. Dr. James Harris, Marshall, Pres.; Dr. L. E. Rutledge, Daingerfield, Secy.

Clinics

Dallas Southern Clinical Society, Dallas, March 12-14, 1956. Dr. Alvin Baldwin, Jr., Dallas, Pres.; Miss Helga Boyd, Medical Arts Bldg., Dallas 1, Executive Secy.

International Medical Assembly of Southwest Texas, San Antonio, Jan. 23-25, 1956. Dr. John C. Parsons, 1125 Nix Professional Bldg., San Antonio, Secy.

New Orleans Graduate Medical Assembly, New Orleans, Feb. 27-March 1, 1956. Dr. Donovan C. Browne, New Orleans, Pres.; Dr. Maurice E. St. Martin, Room 103, 1430 Tulane Ave., New Orleans 12, Secy.

North Texas-Southern Oklahoma Fall Clinical Conference. Dr. E. C. Bebb, Broad, Wichita Falls, Chm.

Oklahoma City Clinical Society Conference. Miss Alma F. O'Donnell, 512 Medical Arts Bldg., Oklahoma City 2, Executive Secy.

Postgraduate Medical Assembly of South Texas. Dr. C. Forrest Jorns, 5644 Lawndale, Houston, Secy.

State Tumor Conference, Wichita Falls, April 4, 1956. Dr. Bailey R. Collins, 925½ Scott, Wichita Falls, Director.

Board Examinations

Texas State Board of Examiners in Basic Sciences. Mrs. Betty Ratcliff, 407 Perry-Brooks Bldg., Austin, Chief Clerk.

Texas State Board of Medical Examiners. Dr. M. H. Crabb, 1714 Medical Arts Bldg., Fort Worth, Secy.

PERSONALS

Drs. Vance J. Elliott, Odessa; *Walter E. McRee,* Port Arthur; and *Nathan H. Topek,* Houston, were inducted into Fellowship in the American Academy of Obstetrics and Gynecology during the December meeting in Chicago.

Dr. May Owen, Fort Worth, has been named Medical Woman of the Year by the Dallas Branch of the American Medical Women's Association. A citation in her honor was presented at the mid-year board meeting of the American Medical Women's Association in Cincinnati.

Dr. Henry A. Holle, Austin, has been appointed a member of the newly created American Medical Association Committee on Geriatrics.

Dr. Thad Shaw, San Antonio, has been elected president of the American Medical Society of Vienna. He is the first physician not practicing in Vienna to be so honored.

Dr. Lyle M. Sellers, Dallas, was a guest speaker at the recent meeting of the Virginia Society of Ophthalmology and Otolaryngology in Richmond.

Dr. Charles T. Stone, Sr., Galveston, was moderator of a panel discussion on geriatric medicine at a recent meeting of the American Geriatrics Society in New York.

Dr. Ben G. Yeager, Wichita Falls, has been certified by the committee for certification of mental hospital administrators of the American Psychiatric Association.

Dr. Ridings E. Lee, president of the Dallas County Medical Society, has been named Oak Cliff's Man of the Month for December.

Dr. G. Lucille Robey, Houston, has been chosen "Typical Business or Professional Woman" by the Business and Professional Women's Club of Houston.

Dr. F. W. Yeager, Sixth District Councilor, has been elected director of the Corpus Christi Chamber of Commerce. Dr. Yeager recently gave his father, *Dr. Charles P. Yeager,* a surprise party on his eightieth birthday. The elder Dr. Yeager has been in private practice more than 50 years.

Dr. Robert L. Daily, Wichita Falls, is the new medical director of the Eureka Life Insurance Company of America.

Dr. Ray Lyman Young, Houston, and Miss Mary Ann Meyer were married September 30. *Dr. Clarence Russell Martin* and Miss Jeanne Alice Snyder exchanged vows October 2 in Houston. On October 29, Miss Patricia Palmer became the bride of *Dr. James Robert McKinney,* McKinney.

New parents of boys are *Dr. and Mrs. Phillips Newman,* October 12, Galveston; *Dr. and Mrs. Sid Stout,* November 25, Fort Worth; and *Dr. and Mrs. A. H. Berryman,* November 18, Fort Worth.

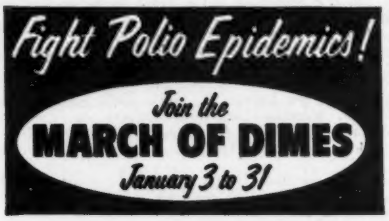
Girls were born to *Dr. and Mrs. S. Gwain Thompson,* November 6, Galveston; *Dr. and Mrs. R. A. Gardea,* September 15, El Paso; *Dr. and Mrs. Ronald Smith,* November 13, Fort Worth; and *Dr. and Mrs. Warren Knox,* November 29, Fort Worth.

POLIOMYELITIS STILL A PROBLEM

Texas still will have problems with poliomyelitis in 1956, reminds Dr. Hart E. Van Riper, medical director of the National Foundation for Infantile Paralysis. The combined efforts of private physicians, public health officers, and the 246 Texas chapters of the Foundation will be necessary to meet the continuing challenge of poliomyelitis in this state.

Although the 1955 incidence of poliomyelitis in Texas was about one-fourth lower than the average of the five previous years, it was comparatively high with reference to other states. To help Texas meet its poliomyelitis problems since 1938, the National Foundation for Infantile Paralysis has contributed the following, supported wholly by March of Dimes Funds:

1. More than $12,570,000 has been spent for the care of patients.
2. The Southwestern Poliomyelitis Respiratory Center, Houston, has received $548,000.
3. National Foundation scholarships and fellowships have been awarded to 103 Texas residents.
4. Contributions of $203,000 have gone toward research, conducted in Texas, in virology, treatment, and after-care of poliomyelitis.
5. Among the Texas institutions that have had March of Dimes research grants are Baylor University College of Medicine, Houston; Crippled Children's Hospital, Marlin; Southwest Foundation for Research and Education, San Antonio; Southwestern Medical School of the University of Texas, Dallas; Texas Scottish Rite Hospital for Crippled Children, Dallas; and the University of Texas Medical Branch, Galveston.



6. Emergency aid during the first 10 months of 1955 included $395,925 to 64 Texas chapters; a total of 101 tank respirators, 85 chest respirators, 35 rocking beds, and 8 physical therapists and 21 nurses specially recruited to work in Texas for the benefit of poliomyelitis patients.
7. A total of 851,000 cc. of Salk vaccine was given to the state to initiate its vaccination program in 1955.

Dr. Van Riper says: "We are at the point now where continuing cooperation of physicians must be had both in administering the vaccine and in caring for patients already paralyzed and for those who will be paralyzed in spite of the vaccine. . . . To pay for research, education, and aid to poliomyelitis patients, the March of Dimes needs $47,600,000 in 1956. Texas physicians, knowing both the need and record, will want to support the 1956 March of Dimes in their own communities."

Congress of Human Genetics

The first International Congress of Human Genetics will be held in Copenhagen, Denmark, August 6, 1956. A copy of the program and further information may be obtained by writing the Secretariat of the First International Congress of Human Genetics, The University Institute for Human Genetics, 14, Tagensvej, Copenhagen, N., Denmark.

Future Nurses Clubs Guide

A new 80 page booklet, "Program Guide for Future Nurses Clubs," has been published by the Committee on Careers, National League of Nursing. It suggests program techniques and various areas of interest which can be explored by teen-agers who want to learn about nursing.

Postgraduate Courses

Clinical Management of Poliomyelitis—February 27-March 2, Houston. The course is designed for physicians, nurses, medical social service workers, and physical and occupational therapists, with emphasis on the severely involved patient, the physician's responsibility in the effective coordination of auxiliary services, and the value of comprehensive care. The course is sponsored by the Baylor University College of Medicine, the Southwestern Poliomyelitis Respiratory Center, and the Jefferson Davis Hospital in cooperation with the National Foundation for Infantile Paralysis. Tuition is $8.50. Applications may be addressed to Dr. William A. Spencer, Medical Director, Southwestern Poliomyelitis Respiratory Center, Jefferson Davis Hospital, 1801 Buffalo Drive, Houston 3.

Practical Bedside Cardiology—March 14-17, Houston. The University of Texas Postgraduate School of Medicine has announced the establishment of the James J. and Una Truitt Chair in Cardiology, and its sponsorship of this course to be given by Dr. Samuel A. Levine, clinical professor of medicine at Harvard Medical School, Boston. Co-sponsors include Baylor University College of Medicine and the Houston Heart Association. Information may be obtained from the University of Texas Postgraduate School of Medicine, Texas Medical Center, Houston 25. The registration fee is $35.

Dr. Truslow Is New Director Of UT Medical Branch

Dr. John B. Truslow, dean of the School of Medicine, Medical College of Virginia, has been appointed executive director of the University of Texas Medical Branch, Galveston. He succeeds Chauncey D. Leake, Ph. D., who resigned last August to accept a position at the Ohio State University Medical School. Dr. Truslow's appointment will become effective April 1.

Dr. Truslow formerly was assistant dean of graduate medicine, College of Physicians and Surgeons, Columbia University, New York. He received his doctor of medicine degree from Harvard Medical School, Boston, and served as medical officer aboard a United States Navy destroyer for five years. Upon his discharge in 1946, he held the rank of commander, and had represented the Navy as a member of the advisory staff of the Senate's subcommittee on wartime health and education.

He is a fellow of the New York Academy of Medicine and a member of Nu Sigma Nu medical fraternity.

UNIVERSITY OF TEXAS MEDICAL BRANCH

The Paul Brindley Memorial Plaque was dedicated by the present junior class at the University of Texas Medical Branch November 8. Contributions from the class, the last to be taught pathology by Dr. Brindley, made the commission of the plaque possible. The faculty has designated lecture room 207, where the plaque is hung, the Paul Brindley Lecture Hall.

Dr. M. Minkowski, emeritus professor of neurology of the Institute of Brain Anatomy, Zurich, Switzerland, is engaged in neurologic research at the Medical Branch as a fellow of the McLaughlin Foundation for Infection and Immunity.

The University of Texas Medical Branch has announced the guest speakers for the forthcoming Pediatric Postgraduate Conference to be held in Galveston February 9-11. Guests will include Dr. Leo Kanner, Director of the Children's Psychiatric Service of the Johns Hopkins Hospital, Baltimore, Md.; Dr. Haddow M. Keith, associate professor of Pediatric Postgraduate School, University of Minnesota School of Medicine, Minneapolis, Minn.; Dr. Herbert C. Miller, professor of pediatrics, University of Kansas School of Medicine, Kansas City, Kan.; Dr. James Dennis, coordinator of resident education, Children's Hospital, Oakland, Calif.; Dr. Clifford G. Grulee, Jr., associate professor of pediatrics and Assistant Dean and Director of the Graduate School of Medicine, Tulane University, New Orleans, La.; and Dr. Vincent Charles Kelley, associate professor of pediatrics, University of Utah School of Medicine, Salt Lake City, Utah.

Texas Association Of Obstetricians and Gynecologists

The Texas Association of Obstetricians and Gynecologists will meet February 18 in Dallas, and Dr. John I. Brewer, professor of gynecology and obstetrics, Northwestern University Medical School, and chairman, Department of Obstetrics and Gynecology, Passavant Memorial Hospital, Chicago, will be the guest speaker.

The program will be as follows:

Mid-Forceps Delivery—Dr. Roy E. Moon, San Angelo.
J. F. Y. Paine Address: Genital Lesions and Childbearing Function—Dr. Brewer.
Management of the Rh Sensitized Patient—Dr. James W. Tabler, Corpus Christi.
Hypofibrinogenemia of Pregnancy—Dr. Doye R. Bridges, Houston.
Hemorrhage in Pregnancy Due to Blood Coagulation Defects—Dr. Jack A. Pritchard, Dallas.
Geriatric Gynecology—Dr. Howard Smith, Marlin.
C. R. Hannah Lectureship: Abnormal Bleeding During the Climacteric—Dr. Brewer.
Panel Discussion: Benign and Malignant Tumors of the Ovaries—Dr. E. K. Blewett, Austin, moderator; Dr. Early Lokey, Amarillo; Dr. R. P. McDonald, Fort Worth; and Dr. John Wall, Houston, panel members.

Two social events have been planned. Members and their wives will be guests of the Dallas group at a cocktail party in the evening, and a luncheon will be held for wives of the doctors present. Mr. Justin Wilson, Baton Rouge, La., will speak at a dinner following the cocktail party.

Hawaii Medical Association

The centennial celebration and scientific congress of the Hawaii Medical Association will be held April 22-29 in Honolulu. Following the scientific meeting, special tours to neighboring islands will be available, and a special tour of Pearl Harbor has been arranged for April 26. Complete details may be obtained from the Hawaii Medical Association, 510 South Beretania, Honolulu 13.

Atlanta Graduate Medical Assembly

The annual meeting of the Atlanta Graduate Medical Assembly will be held in Atlanta February 20-22. Nineteen guest speakers from all fields of medicine will present scientific lectures, and several social events have been planned. Full details of the meeting may be obtained by writing the chairman of the publicity committee, Dr. Mark S. Dougherty, 15 Peachtree Place, N. W., Atlanta.

MEDICAL EDUCATION

During the past year, an all-time record was set for total enrollment in medical schools and for physicians graduated —total enrollment was 28,583, and 6,977 physicians were graduated. This information appears in the fifty-fifth annual report on medical education in the United States and Canada, which has been prepared by the American Medical Association's Council on Medical Education and Hospitals. The report appears in the October 8 issue of the *Journal of the American Medical Association.*

The data show that there are 75 approved four year medical schools and six schools of basic medical science in the United States. Transition from two to four year courses of instruction is taking place at the University of Missouri and the University of Mississippi. Two other medical schools may admit their first classes during the 1956-1957 academic year; they are Seton Hall College of Medicine, South Orange, N. J., and the University of Florida, Gainesville.

Evidence in the report shows that constant efforts are being made by medical schools in the United States and Canada to improve and readjust the curriculums in the light of increasing scientific knowledge.

Approximately two-thirds of the money allotted for basic medical school activities comes from outside grants-in-aid, and approximately 95 per cent of the money expended on research conducted in medical schools comes from similar sources.

Through interstate organization, it has been demonstrated that the duplication of costly professional educational institutions in areas which would have difficulty in financing them can be greatly reduced. The Southern Regional Education Board and the Western Interstate Compact for Higher Education are now under way, and plans have been made to establish a regional program in New England.

Though there is evidence of continuing progress, medical schools still have many problems. Financing needs to be improved, student and faculty recruitment is a constant problem, as is the balancing of teaching and research work. Curriculum readjustments must be made to meet the changing needs, and to take care of graduate and postgraduate education necessities.

Texas Association Of Blood Banks

Dr. O. J. Wollenman, Jr., Fort Worth, was installed as president of the Texas Association of Blood Banks at its December meeting in Houston. During the coming year, the following officers will serve: Dr. C. D. Fitzwilliam, Fort Worth, president-elect; Dr. Louis Manhoff, Jr., San Antonio, vice-president; L. Jean Stubbins, M. T., Galveston, treasurer; and Marjorie Saunders, LL. B., Dallas, secretary.

Guest speakers included Dr. James J. Griffitts, president, American Association of Blood Banks, Miami, Fla.; Mr. Glenn Hill, Ortho Research Foundation, Raritan, N. J.; W. Quinn Jordan, LL. B., executive director, Southwest Blood Banks, Inc., Phoenix, Ariz.; G. Albin Matson, Ph. D., director, Minneapolis War Memorial Blood Bank, Minneapolis; John W. Palmer, Ph. D., vice-president, Hyland Laboratories, Los Angeles; and Dorothy C. Smith, R. N., executive secretary, Florida Association of Blood Banks, Jacksonville, Fla.

There were technical and scientific exhibits. Several social functions were held. The next meeting will be in Dallas, and the date has not been set.

INTERNATIONAL MEDICAL ASSEMBLY OF SOUTHWEST TEXAS

The twentieth anniversary meeting of the International Medical Assembly of Southwest Texas is being held in San Antonio January 23-25. Seventeen guest speakers from almost every field of medicine have come to present portions of the scientific program, and attending physicians have the opportunity to visit several technical exhibits. In addition to scientific attractions, a complete social program has been planned for the physicians and their wives.

Guest speakers include Dr. Vincent J. Collins and Dr. Milton Helpern, New York; Dr. Edmund R. Novak, Baltimore; Dr. Walter C. Alvarez and Dr. William J. Dieckmann, Chicago; Dr. Leonard Lovshin, Cleveland; Major General Dan C. Ogle, United States Air Force, Washington, D. C.; Dr. Earl E. Ewert and Dr. James L. Poppen, Boston; Dr. Frederic C. Bost and Dr. William P. Longmire, Jr., San Francisco; Dr. Lucian W. Alexander, New Orleans; Dr. A. L. Chute, Toronto, Canada; Dr. Harold O. Peterson, St. Paul, Minn.; Dr. E. S. Judd, Jr., Rochester, Minn.; and Dr. Richard W. Zollinger, Columbus, Ohio.

American Cancer Society, Arizona Division

Phoenix, Ariz., will be the site for the January 26-28 meeting of the American Cancer Society, Arizona Division. Topics to be discussed include neoplasms of the thyroid gland, problems in the management of neoplasms of liver and pancreas, leukemia and lymphomas, evaluation of recent treatment of cancer of the stomach, cancer of the skin, psychiatric aspects of malignant diseases, and tumors of the spinal cord. There will be a clinicopathological seminar on neoplasms of the lung, and a review of the annual report of the American Cancer Society.

Guest speakers will include Drs. Alexander Brunschwig, Alfred Gellhorn, Herbert C. Maier, and Brewster Miller, all of New York City; C. H. Hardin Branch, Salt Lake City; Averill Liebow, New Haven; Ian Macdonald, and Rupert B. Raney, Los Angeles; J. A. del Regato, Colorado Springs; Leo G. Rigler, Minneapolis; and David A. Wood, San Francisco.

The registration fee of $5 may be sent to the Arizona Division, American Cancer Society, Registration Committee, Drawer 71, Phoenix.

Institute in Psychiatry And Neurology

The Eighth Annual Institute in Psychiatry and Neurology will be held in North Little Rock, Ark., March 1 and 2. Preceding the institute, February 29, there will be seminars in clinical psychology and psychiatric nursing.

Guest speakers will include Dr. Walter E. Barton, Boston; Dr. J. B. Bounds, Jefferson Barracks, Mo.; Dr. J. F. Casey, Washington, D. C.; Dr. Ralph M. Chambers, Washington, D. C.; Dr. Henry A. Davidson, Cedar Grove, N. J.; Dr. R. H. Felix, Bethesda, Md.; Dr. R. Finley Gayle, Jr., Richmond, Va.; Dr. R. W. Gerard, Ann Arbor; Dr. Francis J. Gerty, Chicago; Dr. Granville Jones, Williamsburg, Va.; Dr. A. Lowell Kelley, Ann Arbor; Dr. Lawrence C. Kolb, New York; Dr. F. Douglas Lawrason, Little Rock; Dr. Theodore Lidz, New Haven; Dr. Karl A. Menninger, Topeka, Kan.; and Miss Mary Redmond, Washington, D. C.

Private Clinics And Hospitals Association

The Private Clinics and Hospitals Association of Texas met December 10-11, 1955, in Austin, and 70 members attended. Officers who will serve during the following year are Dr. J. P. Anderson, Brady, president; Dr. Russell Holt, Meridian, president-elect; and Mr. C. H. Rugeley, Wharton, secretary.

Accreditation of hospitals was a main topic of discussion, and a meeting devoted to this subject will be held in Waco in January. It is hoped that concrete plans for the accreditation of small hospitals and clinics can be worked out for presentation to the Texas Medical Association and the Texas Hospital Association.

The program included discussions on the advantages and disadvantages of foundation ownership of clinics and hospitals, by Mr. Albert Caster, C. P. A., Austin; accreditation of hospitals in Texas, Dr. Anderson; the vocational nurses program, Dr. R. D. Holt, Meridian; the possible advantages of a central buying program, Mr. Bill Schumacher; the preceptor program, Dr. E. S. McLarty, Galveston; and the operation of blood banks in small hospitals, Dr. Mayo Tenery, Waxahachie.

The next meeting will be held in Dallas in December, 1956.

NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

The nineteenth annual meeting of the New Orleans Graduate Medical Assembly will be held February 27-March 1. Eighteen guest speakers will participate, and the program will include 54 discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposiums, color television, medical motion pictures, round-table luncheons, and technical exhibits.

Following the meeting, a tour to the West Indies and Central America will be available for doctors and their families. Details of the New Orleans meeting and postclinical tour are available at the office of the assembly, Room 103, 1430 Tulane Avenue, New Orleans 12.

Texas Proctologic Society

The Texas Proctologic Society will meet in Galveston February 18, and the scientific program will consist of an operative clinic, papers presented by staff members of the University of Texas Medical Branch, and a roundtable discussion for all members of the society. Preceding the discussion, luncheon will be served in the Jack Tar Hotel, and a dinner for the doctors and their wives will be held in the evening.

Travis County Journal

The first issue of the *Journal* of the Travis County Medical Society was distributed to all doctors in the Travis County area in December. The *Journal* is devoted to news of the Travis County Society and its members, and will publish articles on problems of medicine in a general, comprehensive fashion. Editorial and advertising offices are at 1705½ North Congress Avenue, Austin 1.

INTERNATIONAL COLLEGE OF SURGEONS FELLOWSHIPS

During 1956, four oral and four written examinations for fellows in the United States Section of the International College of Surgeons will be conducted. Oral conferences will be held January 23, April 16, August 6, and October 22. Written examinations will be conducted January 30 and 31, April 23 and 24, July 23 and 24, and October 29 and 30. All examinations will be held in Chicago. Further information may be had by writing to the Secretariat of the United States Section, International College of Surgeons, 1516 North Lake Shore Drive, Chicago 10.

UROLOGISTS TO HEAR CALIFORNIAN

A scientific program featuring Dr. Willard Goodwin, associate professor of urology at the University of California at Los Angeles, will be held by the Texas Urological Society in Austin on February 27. Papers by members of the society will complete the all-day scientific session, which will be broken by a luncheon for physicians. The evening before, a reception and dinner for members, wives, and guests is scheduled.

Dr. Rex Carter, Austin, secretary of the society, points out that the requirement for membership is fulfilled by registration at a meeting, and interested physicians are invited. There will be no registration fee for interns, residents, and members of the armed forces.

TEXAS RADIOLOGICAL SOCIETY SPONSORS LECTURESHIP

A visiting lectureship will be sponsored by the Texas Radiological Society for the University of Texas Medical Branch, Galveston, Baylor University College of Medicine, Houston, and the University of Texas Southwestern Medical School, Dallas. The guest lecturer for the first group of lectures, to be given in January, 1956, will be Dr. Franz Buschke, Seattle, Wash., whose subject will be "The Role of Common Sense in Cancer Therapy." Further information concerning the date and time of each lecture may be obtained from Dr. R. P. O'Bannon, 650 Fifth Avenue, Fort Worth, or Dr. Martin Schneider, University of Texas Medical Branch, Galveston.

University of Texas Postgraduate School of Medicine

The University of Texas Postgraduate School of Medicine sponsored several lectures on common problems in obstetrics and pediatrics in Lubbock, October 12. Guest faculty members were Drs. Fred Taylor, associate professor of pediatrics, and Herman G. Gardner, professor of gynecology, Baylor University College of Medicine, Houston.

Fort Worth Heart Association

A one day symposium on diseases of the heart will be held in Fort Worth February 13. Guest lecturers will be Drs. Herrman L. Blumgart, Harvard Medical School, Boston;

Daniel F. Downing, Hahnemann Medical College, Philadelphia; Charles A. Hufnagel, Georgetown University School of Medicine, Washington, D. C.; and Helen B. Taussig, Johns Hopkins Hospital, Baltimore. There will be no registration fee, and the course will be held at the Fort Worth Academy of Medicine Auditorium, 3855 Tulsa Way.

Harris County
Academy of General Practice

Dr. Charles A. Behrens will serve as president of the Harris County Academy of General Practice in 1956. Other officers, elected at a November meeting, include Dr. Homer A. Taylor, Jr., vice-president; Dr. Philip A. Belleggie, secretary; Dr. James Winston Morrison, treasurer; and Dr. Haden E. McKay, president-elect. Dr. Lyman C. Blair was elected a member of the board of trustees. All the officers are from Houston.

Recent Publications By Texas Physicians

Following is a list of recent articles published by Texas physicians and available at the Memorial Library of the Texas Medical Association. Articles appearing in the *Texas State Journal of Medicine* are not included. If a physician who has had a paper printed recently is not named, the Library would appreciate being notified. Also, the Library would like to have two reprints of each article.

Able, L. W.: Gastrointestinal Surgery of Infants, M. Rec. & Ann. *49:*399-401 (Sept.) 1955.

Ainsworth, W. H.: Unstable Fractures of Tibia, South. M. J. *48:*941-944 (Sept.) 1955.

Atkinson, D. T.: Four Vitamins in Ophthalmology, Postgrad. Med. *18:*269-275 (Oct.) 1955.

Baden, W. F.: Umbilical Cord Casualties, Am. J. Obst. & Gynec. *70:*492-499 (Sept.) 1955.

Baird, S. S.; Bush, Leslie; and Livingstone, A. G.: Urethrectomy Subsequent to Total Cystectomy for Papillary Carcinoma of the Bladder: Case Reports, J. Urol. *74:*621-625 (Nov.) 1955.

Barnes, J. P.: Trocar Decompression in Acute Small Bowel Obstruction, Surgery *37:*542-548 (April) 1955.

Beard, E. F.; Butler, D. B.; and Rosenberg, H. S.: Refractory Hypotension Following Removal of Pheochromocytoma, A.M.A. Arch. Int. Med. *96:*273 (Aug.) 1955.

Bernard, J. A.: Insulins, Southwestern Med. *36:*590 (Dec.) 1955.

Bloxsom, Allan: Intravenous Needle Lock, J.A.M.A. *158:* 181 (May 21) 1955.

Blundell, J. R.: Hydronephrosis, M. Rec. & Ann. *44:*425-427 (Oct.) 1955.

Bolen, J. G.: Postoperative Infections of the Salivary Gland, Mississippi Valley M. J. *77:*202-203 (Nov.) 1955.

Breck, L. W.: Basic Principles in the Treatment of Fractures, Southwestern Med. *36:*226 (June) 1955.

Brindley, G. V., Jr.: Early Recognition of Pulmonary Neoplasms, GP *12:*62-73 (Oct.) 1955.

Brindley, H. H.; Phillips, Charles; and Fernandez, Juan: Fibrosarcoma of the Extremities, J. Bone & Joint Surg. *37-A:*602 (June) 1955.

Bromley, S. F.: Early Recognition and Surgical Treatment of Carcinoma of the Lip, Am. Surgeon *21:*962-968 (Oct.) 1955.

Brown, J. M.; Stanage, Willis F.; and Oberst, Byron B.: Colorimetric Determination of Blood Plasma pH, J. Pediat. *47:*571-575 (Nov.) 1955.

Browning, C. W., and Lippas, John: pHisoHex Keratitis, A.M.A. Arch. Ophth. *53:*817 (June) 1955.

Bryant, V. M., and others: Arachnodactyly, J.M.A. Alabama *24:*276-278 (May) 1955.

Bussey, C. D.: Primary Mesenteric Venous Thrombosis, A.M.A. Arch. Surg. *71:*688-693 (Nov.) 1955.

Calderon, R.; Ceballos, J.; and McGrow, J. P.: Metastatic Melanoma of the Stomach, Am. J. Roentgenol. *74:*242-245 (Aug.) 1955.

Cameron, B. M., and McGehee, F. O.: Horseshoe-Shaped Baker's Cyst of the Knee, J. Bone & Joint Surg. *37-A:*863-864 (July) 1955.

Chapman, J. S.: Basic Concepts in Regard to Tuberculosis in Infancy and Early Life, Dallas Med. J. *41:*364 (July) 1955.

Chapman, J. S.: Reaction of Serous Cavities to Blood, J. Lab. & Clin. Med. *46:*48-59 (July) 1955.

Chapman, J. S.: Spontaneous Eruption of Air from the Lung, Am. J. Med. *43:*547-556 (May) 1955.

Clark, R. L., Jr.: Improving Cancer Care, Postgrad. Med. *17:*430 (June) 1955.

Clark, R. L., Jr.; Russell, W. O.; and Old, J. W.: Carcinoma in Situ: A Concept of Cancer Without Invasion, Postgrad. Med. *18:*374-389 (Nov.) 1955.

Clayton, G. W.; Bongiovanni, A. M.; and Papadatos, Constantine: Preliminary Investigations into the Nature of Neutral 17-Ketosteroids in Human Plasma, J. Clin. Endocrinol. & Metab. *15:*693 (June) 1955.

Cohen, I. M.: Effect of Chlorpromazine in Psychiatric Disorders, Am. J. M. Sc. *229:*355-362 (April) 1955.

Coleman, J. A.; Haines, R. D.; and Phillips, Charles: Primary Carcinoma of the Liver, Writings from Scott and White Clinic *2:*5-15 (March) 1955.

Cooley, Denton: Surgical Closure of Ventricular Septal Defects, Surg., Gynec., & Obst. *101:*153-160 (Aug.) 1955.

Cooley, D. A.; Dunn, J. R.; Brockman, H. L.; and DeBakey, Michael: Treatment of Penetrating Wounds of the Heart; Experimental and Clinical Observations, Surgery *37:* 882 (June) 1955.

Cooley, D. A.; Jordan, G. L.; Brockman, H. L.; and DeBakey, M. E.: Gastrectomy in Acute Gastroduodenal Perforation, Ann. Surg. *141:*840 (June) 1955.

Craige, Branch: Disseminated Lupus Erythematosus, No Longer a Rare Disease, Southwestern Med. *36:*538-543 (Nov.) 1955.

Crasilneck, H. B., and others: Use of Hypnoses in the Management of Patients with Burns, J.A.M.A. *158:*103-106 (May 14) 1955.

Crawford, E. S.; Creech, Oscar, Jr.; Cooley, D. A.; and DeBakey, M. E.: Treatment of Arteriosclerotic Occlusive Disease of the Lower Extremities by Excision and Graft Replacement or By-Pass, Surgery *38:*981-992 (Dec.) 1955.

Crawford, E. S., and DeBakey, M. E.: The By-Pass Operation in the Treatment of Arteriosclerotic Occlusive Disease of the Lower Extremities, Surg. Gynec., & Obst. *101:* 529-535 (Nov.) 1955.

Creech, Oscar, Jr.; Hicks, W. M., Jr.; Snyder, H. B.; and Erickson, E. E.: Cholesterol Pericarditis; Successful Treatment by Pericardiectomy, Circulation *12:*193 (Aug.) 1955.

Creech, Oscar; Overton, R. C.; and DeBakey, M. E.: Asymptomatic, Circumscribed (Coin) Lesions of the Lung, J.M.A. Georgia *44:*167-171 (April) 1955.

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CONTRIBUTIONS TO THE LIBRARY

Grateful acknowledgment is made by the Texas Medical Association Memorial Library for the following recent gifts:

Mrs. E. W. Coyle, San Antonio, 1 volume of transactions.
G. D. Searle and Company, 1 book.
Dr. Carl F. Moore, Jr., Austin, 38 journals.
Dr. I. C. Rubin, New York, book of collected reprints.

★ Motion Pictures

Life of Dr. J. M. Travis, Sr.

16 mm., sound, 15 minutes.

This film was produced in honor of the election of Dr. J. M. Travis, Jacksonville, Texas, as General Practitioner of the Year. It portrays his life.

Night Call

16 mm., sound, color, 26 minutes.

A dramatic record of about 24 hours in the life of "a doctor," this film follows the doctor's activities from a middle-of-the-night phone call through a day filled with concern over the diagnosis of a baffling case. The day ends after the weary doctor has successfully diagnosed the case. The film has a touch of ironic humor that makes the doctor and his work real and understandable. This is an impressive film for lay audiences.

Head of the House

16 mm., sound, 40 minutes.

This film depicts the emotional problems of a young boy, his rebellion against parental controls—particularly his father's repressive discipline, and his gradual development into a potential juvenile delinquent. The assistance of a community social worker and a neighborhood welfare house aid in bringing about the development of a better understanding between father and son. This film is excellent for lay groups interested in the subject of mental health.

★ Books

The Behavior Of Pulmonary Tuberculous Lesions

E. M. MEDLAR, *Chief Pathologist, Division of Tuberculosis, New York State Department of Health, Hermann M. Biggs Memorial Hospital, Ithaca, New York; and Lecturer in Pathology, Chest Service, Bellevue Hospital, College of Physicians and Surgeons, Columbia University, New York. 244 pages. $1.50. New York, Published as a part of the American Review of Tuberculosis and Pulmonary Diseases by the National Tuberculosis Association, March, 1955.*

This is an excellent book on the pathogenesis of pulmonary tuberculosis lesions. It presents to the reader the problems of experimental and necropsy studies as well as studies on resected specimens. The author also has included clinical material which is correlated with the pathologic studies. The plates and prints are well done. This book is recommended reading for both pathologists and clinician.

—R. G. McCorkle, Jr., San Antonio.

Cough Syncope

VINCENT J. DERBES, M. D., F.A.C.P., *Professor of Medicine, Director of the Division of Allergy and Dermatology; Tulane University of Louisiana School of Medicine; and* ANDREW KERR, JR., M. D., *Assistant Professor of Medicine, Louisiana State University School of Medicine; Visiting Physician, Charity Hospital of Louisiana, New Orleans. 182 pages. $4.75. Springfield, Ill., Charles C Thomas, 1955.*

This rare symptom-complex is characterized by "loss of consciousness which is preceded by cough." The etiology is unknown.

It occurs almost entirely in middle aged males who are of heavy build and robust, enjoy good food and alcoholic drinks, overeat, oversmoke, and are inclined to levity. The authors state that often the patient is a salesman of alcoholic beverages or a clergyman. But the malady is not unknown among our own kind.

All patients have some kind of respiratory disease, usually mild. It may be emphysema, bronchial asthma, hypersensitive larynx or pharynx, or chronic sinus infection.

The cough is violent and productive of nothing or of a small amount of tenacious, glistening material. It is an explosive cough that builds up high ultra-thoracic pressure.

The syncope comes on suddenly without aura. It lasts a few minutes or only a few seconds. Not only is it not disagreeable; it is actually pleasant. It simulates the blackouts of high altitude or of low oxygen concentration in the blood.

Differentiation from other types of syncope is discussed. The only constant pathologic changes found are those of mild emphysema and bronchial asthma.

Various theories of the mechanisms involved are discussed, but none is wholly accepted. The authors are convinced that the dominant factor is pulmonary vasoconstriction, supplemented by peripheral vasodilatation. There is no known drug that will reverse these conditions. Tobacco smoke is a powerful pulmonary vasoconstrictor.

Treatment is of the accompanying respiratory trouble; reduction of weight, eating, and alcohol consumption; and complete elimination of the smoking habit. This regimen cures some patients and improves many. A few die.

A chapter on medicolegal aspects states that some patients have been absolved of responsibility for wrecks on account of attacks.

The authors' style of writing makes pleasant reading. The egg-shell paper is soothing to the eyes and is a vast improvement over the usual highly glazed stock.

—J. J. Horton, M. D., Buda.

Obstetrics

J. P. GREENHILL, M. D., *Senior Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. ed. 11. 1088 pages. $14. Philadelphia, W. B. Saunders, 1955.*

Even though it is only four years from the tenth edition until this new eleventh edition has appeared, the later volume will be a great help to anyone doing obstetrics. It has been brought up to date and includes all literature up to 1953, which is indeed a tremendous task. The new ideas on the toxemia of pregnancy, abruptio placenta, and the treatment of the afibrinogenemia associated with bleeding in pregnancy are discussed fully, and retrolental fibroplasia of the premature infant is adequately covered.

Discussions of the treatment of pulmonary tuberculosis and infectious diseases in pregnancy have been brought up to date. Another old subject, choriocarcinoma, likewise has been brought into print in this edition.

The problem of erythroblastosis fetalis with the Rh factor has been treated very fairly and has been brought up to date. The chapters of analgesia and anesthesia have been renovated and present nothing particularly new. The diseases of the nervous system are treated as entities.

The chapter on induction of labor and prolonged labor is concise and interesting. The chapter on roentgenology in obstetrics also has been made current and brings up points that are well known but often forgotten.

The chapter relating to the psychosis-psychology of pregnancy and the female during pregnancy is a masterpiece and explains the perversions and mechanisms of misguided hate and love for the baby.

For an explanation of the true mechanism and movement of the fetus in the birth canal during labor and delivery of all the presentations, especially the breech, this book has no equal.

This book is unusual in that it has a very adequate staff of contributors, and the material has been brought up to date. The chapters are replete with copious bibliographies, and most of the "hand me down" of the obstetric world has been eliminated.

—S. J. Merrill, M. D., Brownsville.

Ciba Foundation Colloquia on Ageing

Edited by G. E. W. WOSTENHOLM, O.B.E., M.A., M.B., B.Ch.; *and* MARGARET P. CAMERON, M.A., A.B.L.S.; *assisted by* JOAN ETHERINGTON. *vol. 1. 255 pages. $6.75. Boston, Little, Brown and Company, 1955.*

This short book is the first volume of Ciba Foundation Colloquia on Ageing. The Colloquium was held in London in July, 1954, and included an imposing list of international authorities. The detailed discussions of the various papers presented are as informative as the formal presentations.

In a paper on the pathologic process of ageing it is pointed out that there is no morbid process which is peculiar to ageing alone; death in centenarians always is due to some serious process capable of causing death at any age. In the discussion of a paper on the mental aspects of ageing it is suggested that the loss of drive at the time of retirement occurs because unemployment at retirement is an irreversible process, so that the psyche takes a beating.

Rather detailed technical accounts are given of the effects of ageing on respiratory function, changes with age in diffusion coefficients of solutes for human tissue membranes, ageing of elastic tissue and the systemic effects of elastase, and calcium metabolism in old age. In studies on the 17-ketosteroid excretion in ageing subjects it was found that their excretion is diminished with age. Administration of steroids, chiefly testosterone, to older men (to restore the pattern of 17-ketosteroid excretion to that of younger men) appears to increase muscle strength but may impair memory.

Tissue transplantation of reproductive organs is discussed as a tool for research, not as a means of treatment. In the discussion on the role of nutrition in ageing, findings are presented which suggests that overfeeding during the period of development actually shortens the life span of animals.

This monograph is of greatest interest to research workers in the field of gerontology, but may prove of interest to internists who are particularly interested in geriatrics. It is recommended for the reference library.

—Hugh P. Reveley, M. D., San Antonio.

Practical Medical Mycology

EDMUND L. KEENEY, M. D., *formerly Visiting Physician and Dispensary Physician (Allergy), Johns Hopkins Hospital; Instructor in Medicine, Johns Hopkins University School of Medicine. 145 pages. $4.50. Springfield, Ill., Charles C Thomas, 1955.*

This is an informative, short, concise, well-written, and easily readable monograph. To the reader with little or no knowledge of medical mycology this book can serve only as an introduction to the subject of mycology. To the person who already has fair knowledge of the subject the book can add little or nothing to his presently existing knowledge.

At the beginning of practically every chapter, there is a pictorial outline of the symptomatology, epidemiology, and diagnosis of the fungus disease to be discussed, thereby giving the reader at a glance a mental picture of the disease.

The descriptions of the clinical aspects of the deep or systemic mycoses are concise and comprehensive. At the end of each of the chapters on the deep mycoses, there is a list of references which, for a book this size, must be considered adequate.

There are included even a chapter on "Spores of Saprophytic Fungi as Allergens" and one on "Poisonous Fungi." No references to these topics are given, however.

There is no mention of tinea versicolor and erythrasma in the book; and of course, the rare fungus diseases of the skin are omitted.

The chapter on "Dermatophytosis" is inadequate and is of no practical value to the one who has any knowledge of the dermatomycoses. The statement, "The isolation and classification of the fungus is an academic nicety, but is not always essential for the proper treatment of the patient," p. 107, is no more justified than would be a similar statement regarding bacteriologic studies in other diseases, for example, pneumonia. The difficulties, pitfalls, and intricacies of diagnosis and treatment are completely ignored. The absolute necessity of adequate mycologic diagnosis for the proper management of tinea of the scalp is minimized or ignored. The problems of tinea of the nails and Trichophyton rubrum infections are not discussed. No references are given for this chapter.

Details of laboratory methods and procedures are omitted

or so very scantily dealt with as to make the book impractical, particularly to the person who does office mycology and to the laboratory technician.

The book can best be considered as an outline of, or brief introduction to, clinical mycology; but it can be of no practical value as a reference text of general mycology as its name might imply.

—Lee J. Alexander, M. D., Dallas.

Angiographic Localization of Intracranial Masses

ARTHUR ECKER, M. D., Ph. D., *State University of New York, Upstate Medical Center, Syracuse Memorial Hospital, Syracuse; and* PAUL A. RIEMENSCHNEIDER, M. D., *State University of New York, Upstate Medical Center, Syracuse Memorial Hospital, Syracuse. 433 pages. $13.50. Springfield, Ill., Charles C Thomas, 1955.*

This book is well organized to present under one cover a collection of information in regard to (and illustrative examples of) the localization of intracranial masses by carotid and vertebral arteriography. A similar volume has not been encountered previously in the English language by this reviewer. Excellent line drawings to illustrate the fundamentals of localization by arterial displacement are presented. The drawings serve a good purpose in orientation of the student. A wide variety of lesions are presented, illustrating the value of arteriography to extend well beyond the limited field of diagnosis and localization of aneurysms and angiomatous malformations.

The book is not one of wide enough scope to be of use to persons outside the fields of neurology, neurosurgery, and radiology; but it does fill a gap in the literature of those specialties. The relatively recent development of intracranial angiography had led the student and resident to gain information through articles in the literature and through his own limited personal experience. Previously there has been no book readily available to help the neurosurgery and radiology residents with some of the pitfalls and terminology of angiographic localization. Individual hospital radiologists and practicing neurosurgeons probably will find valuable cases outside the scope of their personal experience recorded here. The binding, paper, and printing are of good quality.

—Edmund M. Fountain, M. D., Houston.

A Textbook of Physiology

Edited by JOHN F. FULTON, M. D., *Sterling Professor of the History of Medicine, Yale University School of Medicine. ed. 17. 1,275 pages. $13.50. Philadelphia, W. B. Saunders Company, 1955.*

Howell's "Textbook of Physiology" has long been one of the standard texts used in the teaching of physiology. This new, seventeenth edition has followed the general plan of recent previous editions in organization and method of presentation. The editor and some 30 contributors have done well in following the two guiding principles set forth by Howell in the original text: "first, the importance of simplicity and lucidity in the presentation of facts and theory; and, second, the need of a judicious limitation of material selected."

As in previous editions, the physiology of the muscles and the nervous system has been given a prominent place. The first four sections of the book, dealing with these subjects, make up 40 per cent of the total text, leaving only 60 per cent of the text to cover all other organ systems and topics presented. Many of the sections have been completely rewritten and others have been extensively revised. The sections on respiration, body fluids, and kidney function deserve special mention, as they are excellent.

The text is well illustrated, in many instances with classical illustrations and data. The use of very small type for quotations, additional notations, and explanatory statements in the text has been kept to a minimum.

It is the reviewer's opinion that this seventeenth edition will continue to serve as an excellent text for the student of physiology and medicine. Although clinical application is not stressed, the practitioner of medicine will find this text a good reference source for review or restudy of basic physiologic principles.

—Nicholas C. Hightower, M. D., Ph. D., Temple.

Kinesiology

ARTHUR STEINDLER, M. D., (Hon) F.R.C.S., Eng. F.A.C.S., F.I.C.S., *Professor of Orthopedic Surgery, Emeritus, State University of Iowa; Head of Orthopaedic Department, Mercy Hospital, Iowa City. 708 pages. $19.75. Springfield, Ill., Charles C Thomas, 1955.*

The full title of this book by Dr. Steindler is "Kinesiology of the Human Body Under Normal and Pathological Conditions." In it he has shown with amazing clarity, by the written word, by photograph, and by drawings, the important relationship of muscle and joint in the mechanics of normal and pathologic motion. The author treats his subject in an orderly progression, covering in sequence, physiology, structure, and kinetics from the point of view of both the normal and abnormal. The mechanics of joint and muscle action, the patho-mechanics of muscle function, body balance, and body equilibrium also are discussed clearly and with simplicity, so as not to discourage the student. The major part of this book is concerned with the study of mechanics, dynamics, and patho-mechanics of the musculoskeletal system by regions and by individual joints. The normal is covered first, laying a foundation for the discussion of the pathologic. The importance of muscle kinetics is effectively tied in with accepted surgical procedures.

Although this book is of a highly specialized nature, it is not sufficiently so to preclude its being read and appreciated by the general practitioner. The orthopedist and the surgeon engaged in traumatic work will find Dr. Steindler's book to be enjoyable reading and thought provoking. To the orthopedic surgeon, Dr. Steindler has long been a source of knowledge and encouragement. In this book again he has given the surgeon the benefit of his years of work and study and led him to a better understanding of muscle function.

—Robert C. Cornell, M. D., El Paso.

Surgery of the Alimentary Tract

RICHARD T. SHACKELFORD, M. D., *Assistant Professor of Surgery, Johns Hopkins University School of Medicine, and* HAMMOND J. DUGAN, M. D., *Assistant in Surgery, Johns Hopkins University School of Medicine. 3 vols. 2,575 pages. Set $60. Philadelphia, W. B. Saunders Company, 1955.*

This three volume discourse could be described as the surgical answer to Bockus' "Gastroenterology." Unfortunately, its fate is similar to any text in that some data are outmoded by the time of publication.

These volumes should be of particular value as sources of reference for those surgeons who find it necessary to perform an infrequent gastrointestinal procedure. The sections dealing with medical topics of physiology, diagnosis, and indications for surgery are adequate and concise. Thus,

the gastroenterologic internist also should find Dr. Shackelford's work to be useful. The illustrations and the descriptions of surgical technique are well done.

In summary, the volumes represent a valuable contribution in the reference field of gastrointestinal surgery and will be of value to any physicians dealing with gastroenterologic patients.

—O. Roger Hollan, M. D., San Antonio.

★ American Medical Association

Boston Clinical Meeting

At the ninth annual clinical meeting in Boston, the House of Delegates of the American Medical Association considered social security, the report of the Committee on Medical Practices, grievance committees, and revisions of the code of medical ethics among the major subjects of discussion and action.

The meeting was attended by the following delegates and alternate delegates of the Texas Medical Association: Dr. T. C. Terrell, Fort Worth; Dr. J. C. Terrell, Stephenville; Dr. M. O. Rouse, Dallas; Dr. J. B. Copeland, San Antonio; Dr. John L. Otto, Galveston; and Dr. L. C. Heare, Port Arthur. When it became apparent that Texas had only six instead of seven delegates or alternates present at the meeting, Dr. Roy T. Lester, Dallas, was appointed by long distance telephone to serve as an alternate delegate.

Major action was taken on the following subjects:

Social Security.—Major legislative policy action involved HR 7225, known as the Social Security Amendments of 1955, and a resolution was adopted urging that a careful survey of social security in the United States be made and that the best efforts of the AMA be devoted to procuring and providing full information on the medical aspects of disability, rehabilitation, and medical care of the disabled.

OASI Coverage of Physicians.—It was resolved that the AMA recommend to state societies that they poll their entire membership on the question of coverage of physicians by social security and that the results of the polls be transmitted to the Board of Trustees of the AMA.

Report on Medical Practices.—A substitute resolution offered by the Reference Committee on Insurance and Medical Practices, which studied the basic causes leading to certain unethical practices and unfavorable publicity, was adopted. It provided for the creation of a Continuing Committee on Medical Practice to study the relative value of diagnostic, medical, and surgical services. The House of Delegates also approved a supplementary report by the Board of Trustees which suggested that all nonsurgical groups be asked for suggestions and cooperation in carrying out a public education program, that various specialty boards be encouraged to reappraise their practice restrictions, and that the AMA should continue to discourage arbitrary restrictions by hospitals against general practitioners.

Grievance Committees.—A recommendation was made that a brochure be published which would outline recommendations regarding the activities of grievance committees and would include practical suggestions.

Medical Ethics.—A proposed revision of the Principles of Medical Ethics and Precepts of Manners of the American Medical Association was tabled for further consideration at the next annual session. It was recommended that the proposals be widely publicized before being reconsidered.

Miscellaneous Actions.—Several miscellaneous actions were taken, including recommendations that the Board of Trustees give consideration to a dues increase, with the increase earmarked for the American Medical Education Foundation; and that further purchase of Salk vaccine be carried on through the usual channels of distribution. The Woman's Auxiliary was commended for its support of medical education, and the Sears-Roebuck Foundation was commended for establishing its new plan of assistance for new medical units. A resolution was adopted on the practice of pathology declaring opposition to the division of any branch of medical practice into so-called technical and professional services.

Five of the eight resolutions presented by the Texas delegation were adopted, one was tabled for further study, and two were disapproved.

Dr. E. Roger Samuel, Mount Carmel, Pa., was named General Practitioner of the Year. A special citation was presented to Dr. Torald Sollmann, Cleveland, Ohio, for his "outstanding service to the medical profession and on behalf of the advancement of medical science." He is a charter member of the AMA Council on Pharmacy and Chemistry, and has served as its chairman since 1936.

Total registration reached 8,637, including 3,779 physicians.

CONGRESS ON INDUSTRIAL HEALTH

The Sixteenth Annual Congress on Industrial Health will be held January 23 and 24 in Detroit, Mich. The congress is sponsored by the Council on Industrial Health of the American Medical Association, the Michigan State Medical Society, the Wayne County Medical Society, the Michigan Industrial Medical Association, the Detroit Industrial Physician's Club, and the Detroit Society for Surgery of Trauma. Principal speakers will be Dr. Elmer Hess, President of the American Medical Association, and Benson Ford, vice-president of the Ford Motor Company.

★ Texas Medical Association

Insurance Deadline Extended

The charter enrollment period for the group disability insurance program recently adopted by the Texas Medical Association, originally scheduled to end December 31, has been extended to January 31. This extension, requested by the Board of Trustees because of the holiday season and congestion in the mails, will permit more members of the Association to take advantage of this plan, designed to cover any member up to age 70 years regardless of his past physical history or condition. After the initial enrollment period, physicians 60 years of age and older will not be accepted

for insurance, and Lumbermen's Mutual Casualty Company, which is underwriting the plan for the Texas Medical Association, will be under no obligation to accept without limitation those whose medical history is questionable.

Application blanks and further details have been mailed directly to each member of the Association and appear in the October and November issues of the JOURNAL. They also may be obtained from the headquarters of the Texas Medical Association, 1801 North Lamar Boulevard, Austin. The Charles O. Finley & Company of Chicago, administrator of the insurance program, has opened a branch office in Austin, which is housed temporarily in the Association building.

LOCAL COMMITTEES NAMED

Members of the local committees for the 1956 Galveston annual session of the Texas Medical Association, which is to be held April 21-25, have been announced by Dr. Edward R. Thompson, chairman of the Committee on General Arrangements. The committees are as follows:

Alumni and Fraternity.—John W. Middleton, Chairman; Robert E. Casey; Leo Duflot; Kenneth M. Earle; G. W. N. Eggers; Burke Evans; Marshall L. Fowler; Carl J. Fuchs; William W. Hander; Titus H. Harris; J. L. Jinkins; Jesse B. Johnson, Jr.; Lawrence G. May; A. O. Singleton; Worth Walton.

Finance.—A. N. Sarwold, Chairman; Fred W. Aves; Elwood E. Baird; David Blacklock; Willard R. Cooke; Cesar Elizondo; Ben P. Fleming; O. T. Kirksey; George S. McReynolds; Albert M. Magliolo; Edgar J. Poth; Norman D. Schofield; Ian Thompson.

Halls and Lanterns.—E. F. Jones, Jr. and E. J. Lefeber, Co-Chairmen; Charles R. Allen; G. David Ford; A. J. Jinkins; Edward T. Kealey; G. R. Manske; James P. Parker; M. L. Ross; S. R. Snodgrass; William F. Spiller; Clarence S. Sykes.

Hotels.—William Wilson, Chairman; E. Sinks McLarty; E. Sinks McLarty, Jr.; Joseph C. Magliolo; W. T. Matlage; J. Fred Mullins; Marcel Patterson; Nathan Prujansky; R. H. Rigdon; L. E. Rosenblad.

Information.—Herman Weinert, Chairman; Virgil C. Baxter; E. Ivan Bruce; Sidney P. Cooper; Newton E. Dudney; William M. Gambrell; Ira J. Jackson; David C. Miesch; Mack J. Moseley; Clarence F. Quinn; H. Reid Robinson; Martin Schneider; Eugene L. Smith; Elbert M. Stanton.

Memorial Services.—Robert M. Moore, Chairman; George W. Beeler; Carl U. Dernehl; Edward D. Futch; Wendell D. Gingrich; Raymond L. Gregory; Elihu I. Klein; William B. Sharp; Cam Stiernberg; Charles T. Stone.

Public Lectures.—W. C. Levin and Andrew J. Magliolo, Co-Chairmen; Victor C. Calma; John H. Childers; Irvin M. Cohen; Robert N. Cooley; Harry K. Davis; Daniel H. Eames; Theo M. Frank; Arild E. Hansen; Norman Jarrell; J. L. Jinkins, Jr.; Peter B. Kamin; Henry A. Schmidt; James B. Stubbs.

Publicity.—E. Peter Garber, Chairman; William F. Anderson; Truman G. Blocker; D. R. Danforth; A. W. Harrison; Charles A. Hooks; Jack B. McGolrick; Hyman W. Paley; G. Douglas Williams.

Scientific and Technical Exhibits.—Stephen R. Lewis, Chairman; William H. Ainsworth; Hamilton Ford; W. J. Jinkins; Jesse B. Johnson; Eugene C. McDanald; Theo C. Panos; Arthur Ruskin; V. A. Stembridge; Douglas D. Stiernberg; Spencer G. Thompson; Leonard Twidwell; McClure Wilson.

Social.—M. A. Caravageli, Chairman; Weldon G. Kolb; Amedeo Magliolo; John L. Otto; William B. Potter; Edward Randall; Edward H. Schwab; Robert R. Simpson; William H. Tinsley; Martin L. Towler; Richard R. Verrett.

Sports:

Fishing.—W. W. Stephen, Chairman; John J. Delaney; Robert P. Green; John McGivney.

Golf.—C. T. Adriance, Chairman; Wootten Brown; W. L. Marr; Earl B. Ritchie; Herschel G. Tree.

Skeet.—G. W. N. Eggers, Jr., Chairman; Francis A. Garbade; Edward B. Rowe; John M. Thiel.

Transportation.—Paul B. deMesquita, Chairman; William C. Fisher; Sol Forman; Reagan H. Gibbs; Milton R. Hejtmancik; Garth L. Jarvis; John E. Johnson; Julian W. O'Bryant; E. Hopkins Stirling; Garland O. Wellman; Warren S. Williams; Fred Wolma.

Women Physicians.—M. Ruth Baxter, Chairman; Luba E. Anigstein; Gwendolyn Crass; Virginia I. Blocker; Harriet M. Felton; Grace Jameson; Gaynelle Robertson; Joanna M. Rosenblad; Caroline W. Rowe; Nina Mae Sisley; Ida K. Walton.

All applications for hotel accommodations in Galveston during the annual session should be addressed to Miss Grace J. Amundsen, executive secretary of the Galvston County Medical Society, Room 821, Buccaneer Hotel, Galveston. Until February 15, preferential consideration will be given to Association officials, delegates, and guest speakers, who will have rooms in the Galvez and Buccaneer Hotels. After that date, all unassigned rooms will be available on a first come, first served basis. A list of hotels and tourist courts, with rates and number of rooms available, appears in the September, 1955, issue of the *Texas State Journal of Medicine.*

Donald M. Anderson Appointed Assistant Executive Secretary

Donald M. Anderson, Austin, will become assistant executive secretary of the Texas Medical Association on February 1. He will assume the duties of J. Stuart Page, field director, who moved to Dallas January 1 to accept a position as executive secretary of the Municipal Contractors Association.

Mr. Anderson has been assistant director of nonacademic personnel at the University of Texas since 1952, and has had extensive experience in public speaking and research work. He received his bachelor of arts degree in 1950 from the University of Texas, majoring in public administration. His master of arts thesis is in progress, and he has completed more than half the course necessary for a degree in law.

Serving with the Eighth Army Air Force for four and one-half years, Mr. Anderson held ranks from private to captain, and had combat flying experience in the European theater during World War II. He is married and has no children.

★ County Societies

Brazoria County Society

December 1, 1955

At the December 1 meeting of the Brazoria County Medical Society in Freeport the following officers were elected for the coming year: Henry K. May, Lake Jackson, president; James A. Stewart, Freeport, vice-president; Carlos E.

Fuste, Jr., Alvin, secretary; John S. Caldwell, Jr., Velasco, treasurer; Ralph E. Gray, Velasco, delegate; and Dr. Fuste, alternate delegate.

—Reported by Carlos E. Fuste, Jr., Secretary.

Cameron-Willacy Counties Society

November 21, 1955

Eighty-four members and guests were present for the November 21 meeting of the Cameron-Willacy Counties Medical Society in Harlingen. Dr. Sanford Glanz, Corpus Christi, presented the scientific program, "Treatment and Initial Care of Acute Facial Injuries." It was decided to authorize the professional relations committee to publicize by newspapers and television the availability of such a committee. A television committee was set up to work out and present programs on the local stations.

—Reported by Howard E. Tewell, Jr., Secretary.

Dallas County Society

October 11, 1955

Members of the Dallas County Medical Society were dinner guests of the staff of St. Paul's Hospital October 11. Mr. Millard Heath, executive secretary of the society, gave five minutes of medical news, and 15 new members were elected. The scientific program, "Talking with the Patient," was presented by Stewart Wolf, Norman, Okla.

—Reported by Glenn D. Carlson, Secretary.

November 8, 1955

Meeting in Dallas November 8, members of the Dallas County Medical Society heard the annual Charles M. Rosser lecturer, Harry E. Bacon, who is professor and head of the Department of Proctology, Temple University School of Medicine, Philadelphia. His topic was "Extended Resection for Cancer of Rectum and Sigmoid." Thirteen new members were elected.

—Reported by Glenn D. Carlson, Secretary.

El Paso County Society

October 11, 1955

J. Edwards Stern, El Paso, presented a scientific paper on depression at the October 11 meeting of the El Paso County Medical Society. A film on bleeding control also was shown.

Harris County Society

October 5, 1955

In a special session in Houston October 5, the Harris County Medical Society members agreed that medicine should do more for the indigent of Harris County. A special committee was appointed to study the situation and make recommendations to the society. About 400 physicians attended the meeting.

November 9, 1955

At a business meeting November 9 in Houston, members of the Harris County Medical Society elected the following officers for 1956: M. D. Levy, president-elect; Joseph W. King, secretary; and Curtis H. Burge, treasurer. Everett B. Lewis will serve as president in 1956. All the officers are from Houston.

Hill County Society

December 13, 1955

The Hill County Medical Society met in Hillsboro December 13 to elect officers for 1956. Those elected were Garland McPherson, president; Hendley McDonald, vice-president; Charles A. Garrett, secretary-treasurer; Dick Cason, delegate; and R. W. Shirey, alternate. All the officers are from Hillsboro.

—Reported by Dick Cason, Reporter.

Lamar County Society

November 3, 1955

Nineteen members and three guests of the Lamar County Medical Society met November 3 in Paris for a dinner, a brief business meeting, and the scientific presentation, "Socialization of Medicine and Insurance Problems" by Roy Lester and Ralph E. Webb, Dallas.

—Reported by Harold E. Hunt, Secretary.

Lubbock-Crosby Counties Society

October 4, 1955

About 40 members attended the October 4 meeting of the Lubbock-Crosby Counties Medical Society in Lubbock. Four members volunteered to conduct physical examinations for the ROTC unit at Texas Technological College. F. L. Lovings and J. A. Chatman were accepted as new members of the society.

E. E. Muirhead, Dallas, presented a paper, "Diagnosis and Treatment of Hemolitic Anemia."

Tarrant County Society

November 1, 1955

The scientific program for the November 1 meeting in Fort Worth of the Tarrant County Medical Society was presented by Russell L. Cecil, medical director of the Arthritis and Rheumatism Foundation, New York City. His topic was "Diagnosis and Treatment of Rheumatoid Arthritis." About 140 members were present. Tribute was paid to John B. Cummins, who was 97 years old November 7; R. G. Baker and L. H. Reeves spoke briefly, and Dr. Reeves said that a chair would be delivered to Dr. Cummins from the society.

The society adopted the amendment deleting the word "white" from the constitution.

An amendment providing 24 months of probationary membership with 30 per cent attendance at meetings of the medical society before a physician could be elected to regular membership was defeated by a vote of 68 to 12. Motion was made and carried that delegates of the Tarrant County Society be instructed to oppose this issue in the House of Delegates of the Texas Medical Association.

—Reported by Miss LaVerne Downtain, Executive Secretary.

November 18, 1955

The Tarrant County Medical Society met in Fort Worth November 18 and heard Mr. J. T. Boothman, chairman of the public relations committee of the Tarrant County Pharmaceutical Association, speak regarding the new narcotic law which became effective in September. "Surgical Occlusion of Anterior Choroidal Artery in Parkinsonism," by W. W. McKinney, Fort Worth, was the scientific portion of the program.

—Reported by S. W. Wilson, Secretary.

Webb-Zapata-Jim Hogg Counties Society

December 6, 1955

Members of the Webb-Zapata-Jim Hogg Counties Medical Society met December 6 in Laredo and elected William R. Powell, president; P. H. Powell, Jr., vice-president; and L. G. Cigarroa, secretary. All are of Laredo. Special guests at the meeting were Mr. J. Stuart Page, Austin, field director of the Texas Medical Association; and F. W. Yeager, Corpus Christi, Sixth District Councilor.

Wichita County Society

November 8, 1955

The Allison Walgreen Drug Company was host to the Wichita County Medical Society at a meeting November 8 in Wichita Falls. A social hour and dinner preceded the business meeting.

—Reported by Frank S. Browne, Secretary.

★ District Societies

Tenth District Society

December 7, 1955

The following scientific program for the December 7 meeting of the Tenth District Medical Society was presented by staff members of the M. D. Anderson Hospital and Tumor Institute, Houston, and was arranged by the Texas Division of the American Cancer Society:

Panel Discussion: Carcinoma of Stomach—Vincent Collins, George Jordan, and Arch Brown.
Estimation of Duration of Human Cancer—Vincent Collins.
Carcinoma of Lung—George Jordan.

L. C. Heare, Port Arthur, Councilor of the Tenth District Society, reported on the interim meeting of the American Medical Association. At the business meeting which followed, Taylor Walker, Beaumont, was elected president; Rider Stockdale, Jasper, vice-president; and Alan E. Hubner, Beaumont, secretary-treasurer.

Twelfth District Society

January 10, 1956

The scientific portion of the program for the January 10 meeting in Bryan of the Twelfth District Medical Society was presented by members of the Baylor University College of Medicine, Houston. Topics and speakers were as follows:

Clinical Aspects of Poliomyelitis—Robert J. Jackson, Jr.
Inefficient Uterine Action—Jack Moore.
Newer Sulfonamides in Infectious Diseases—Ellard M. Yow.
Modern Concepts in Treatment of Epilepsy—William S. Fields.
Chemotherapy of Leukemia—Robert A. Hettig.
Significance of Coin Lesions of Lung—Oscar Creech.
Pulmonary Emphysema—James K. Alexander.
Emotional Factors in Gastrointestinal Disorders—Spencer Bayles.
Current Status of Infant Feeding—Fred M. Taylor.
Current Status of Direct Heart Surgery—Denton A. Cooley.

The luncheon speaker was Stanley W. Olson, dean of Baylor University College of Medicine. The Woman's Auxiliary to the Twelfth District Medical Society met concurrently.

Regional Legislative Conference

"Free medicine's first concern is the health and well being of the people of our nation," Dr. John E. McDonald, Tulsa, Okla., chairman, told those attending the Regional Legislative Conference of the American Medical Association held in Dallas on November 19. "It is our urgent task to educate the American public and legislators at local, state, and national levels to this fact, if we are to succeed in defeating the creeping socialistic juggernaut which is poised to crack our defenses on all fronts," continued Dr. McDonald, who is a member of the Legislative Committee of the AMA.

Participating in the conference with physicians were representatives from Woman's Auxiliary organizations on various levels, the legislative committee of which works to promote interest in medical legislation and to disseminate information among its members and the public. The committee of the State Woman's Auxiliary works closely with the Texas Medical Association in carrying out its legislative policies.

Throughout the conference, it was emphasized that doctors also are citizens with an obligation to posterity to preserve the freedom of this nation, as well as the freedom of medicine. Grass roots activities and support are the cornerstone of this crusade, and auxiliary members have proven themselves particularly adept in assisting their husbands in this phase of the work. Such a foundation insures a solid edifice comprising county, state, and national medical organizations and their parallel auxiliaries. So fortified, medicine's position becomes more effective when the profession's views are made known to legislators.

Legislation pertaining to health reinsurance and mortgage loan insurance, medicine and the treaty power (Bricker Amendment), veterans medical care, tax deferred retirement plans (Jenkins-Keogh bills), military medicine (including care of dependents of the military), federal aid to medical education, and compulsory disability coverage under Title II of the Social Security Act were discussed. A report from the Washington office was made by Thomas M. Alphin, M. D., director. Progress of selected legislation under consideration in Congress was reported by R. G. Van Buskirk, Chicago, Secretary, Committee on Legislation, AMA. An open forum brought forth much information and clarified obscure points.

"If every physician in America and his wife gave one thousand dollars a year and one third of their time to defending the principles of Americanism, it would be a wise investment," declared Dr. F. J. L. Blasingame, Wharton, member of the Board of Trustees of AMA. And he further

Officers of the Woman's Auxiliary to Texas Medical Association: President, Mrs. Joseph H. McCracken, Jr., Dallas; President-Elect, Mrs. R. C. Bellamy, Liberty; First Vice-President, Mrs. Harold Lindley, Pecos; Second Vice-President, Mrs. William C. Barksdale, Borger; Third Vice-President, Mrs. Scott H. Martin, San Angelo; Fourth Vice-President, Mrs. L. L. D. Tuttle, Houston; Fifth Vice-President, Mrs. John C. Parsons, San Antonio; Treasurer, Mrs. J. C. Terrell, Stephenville; Recording Secretary, Mrs. Franklin Campbell, Fort Worth; Corresponding Secretary, Mrs. O. M. Marchman, Jr., Dallas; Publicity Secretary, Mrs. Joe Thorne Gilbert, Austin; Parliamentarian, Mrs. O. W. Robinson, Paris.

warned that "only by a herculean effort can we save free medicine in this country."

Among the distinguished guests attending the conference were Mrs. Mason G. Lawson, Little Rock, Ark., President of the Woman's Auxiliary to the American Medical Association; Mrs. Charles L. Goodhand, Parkersburg, W. Va., Chairman of Legislation, Woman's Auxiliary to the American Medical Association; and Mrs. R. C. Bellamy, President-Elect of the Woman's Auxiliary to the Texas Medical Association.

—MRS. F. PAUL BUROW, Killeen,
Editor, News Letter.

★ County Auxiliaries

Mrs. Joseph H. McCracken, Jr., Dallas, President of the Woman's Auxiliary to the Texas Medical Association, has been touring numerous county auxiliaries during the past few months. She was a special honor guest at the opening meetings of the year of the *Dallas* and *Bell Counties Auxiliaries* early in October. As honor guest and principal speaker at the October 19 meeting of the *Galveston County Auxiliary,* she outlined the activities of the new term on a statewide level, and emphasized maintenance of Student Loan, Memorial, and Library Funds. Sharing honors with her were Mrs. Andrew S. Tomb, Victoria, Eighth District Council Woman, and Dr. Joseph C. Magliolo, Dickinson, president of the Galveston County Medical Society.

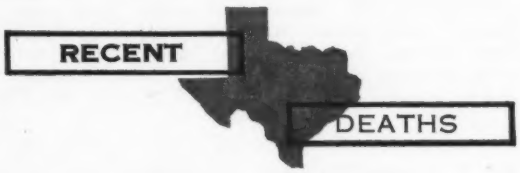
On visits to the *Nacogdoches, Jasper-Newton,* and *Angelina Counties Auxiliaries,* Mrs. McCracken was accompanied by Mrs. L. C. Heare, Port Arthur, Tenth District Council Woman. All the meetings were in mid-October. In Nacogdoches and Lufkin (Angelina County) luncheon was served, and the Jasper County meeting was in the home of Mrs. William S. Sanders, Jasper. The *Tarrant County Auxiliary* honored Mrs. McCracken with a brunch December 9.

The newly organized *Tierra Blanca Auxiliary* has elected Mrs. Roy J. Grubbs, Hereford, president; Mrs. J. W. Spence, Dimmitt, vice-president; and Mrs. Bert A. Masters, Canyon, secretary-treasurer. The new group honored their husbands in December with a Christmas party.

Officers of the *Dallas County Auxiliary* for the coming year are Mrs. Warren A. Shoecraft, president; Mrs. O. M. Marchman, Jr., president-elect; Mrs. Floyd S. Franklin, first vice-president; Mrs. William B. Dean, second vice-president; Mrs. James B. Howell, third vice-president; Mrs. T. S. Barnes, recording secretary; Mrs. Leon Hodges, corresponding secretary; Mrs. Benjamin Barzue, treasurer; Mrs. J. O. S. Holt, assistant treasurer; Mrs. Ridings E. Lee, parliamentarian; Mrs. F. E. Gessner, historian, and Mrs. Robert L. Moore, publicity chairman. In November, the group held a silver shower to buy bed lamps for patients in the Woodlawn Hospital.

Members of the *Camp-Morris-Titus Counties Auxiliary* met at the home of Mrs. R. L. Johnson, Pittsburg, early in October. A film on drug addiction was presented. At the *Kerr-Kendall-Gillespie-Bandera Counties Auxiliary,* the Rev. Donald R. Raish spoke on public information and service. The meeting was held in the home of Mrs. Dwight R. Knapp, Kerrville, and Mesdames Hugh A. Drane, Jr., and C. F. Culver were assisting hostesses. "Action for Community Health and Safety" is the season's theme for the *Bexar County Auxiliary,* and the first program, "Action for Mental Health," was presented early in October at a luncheon meeting. Dr. J. Layton Cochran, President of the Texas Medical Association, was an honor guest.

Members of the *Henderson County Auxiliary* answer roll call with a capsule of current medical news. They plan to sponsor a future nurses project this year, and at the October meeting, excerpts from *Today's Health* were given regarding the future school situation.



DR. C. S. TRUITT

Dr. Crawford S. Truitt, Daingerfield, Texas, died October 29, 1955, in a Gilmer hospital of cardiac asthma.

He was the son of E. L. and Elizabeth Ann (Walker) Truitt, and was born May 28, 1878, in Upshur County. After being graduated from Jeff Davis College, Pittsburg, Texas, Dr. Truitt taught school in Dianna, and later was a prescriptionist in Daingerfield, Naples, and Bells. He then entered Baylor University College of Medicine, Dallas, and

DR. C. S. TRUITT

received his doctor of medicine degree in 1908 from the Barnes Medical College, St. Louis. Dr. Truitt interned in the Female Hospital, St. Louis, and practiced medicine briefly in Gilmer before he settled in Daingerfield, where he had practiced 45 years.

He was a member of the Morris County Medical Society, which he served as president in 1951 and 1952; the Texas Medical Association; and the American Medical Association.

An obituary ordinarily will not be published more than four months after date of death. Cooperation in reporting deaths of physicians and in furnishing appropriate biographical material promptly is solicited.

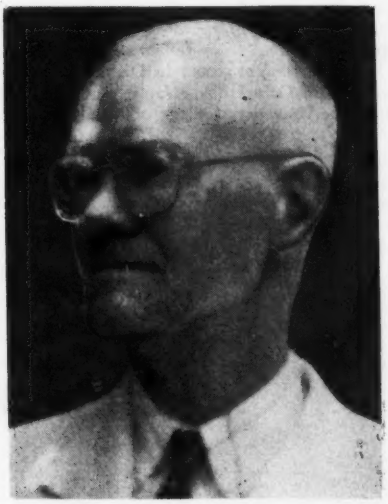
He was city health officer and surgeon for the Louisiana, Arkansas, and Texas railroad.

Dr. Truitt was mayor of Daingerfield from 1934 until 1944, and during that time he was active in completing the Daingerfield State Park and in securing the completion of a highway from Daingerfield to Longview. During his administration, the city completed its first municipally owned water and sewer system. He was a steward and director of the First Methodist Church, and served a term as president of the Chamber of Commerce.

Miss Alice Katherine Howard and Dr. Truitt were married March 7, 1910. Survivors include Mrs. Truitt; a son, Master Sergeant Kenneth H. Truitt, Headquarters, United States European Command, Paris, France; a sister, Mrs. Artha Anderson, Bettie; a brother, Matt Truitt, Texarkana; and two grandchildren.

DR. C. L. McCLELLAN

Dr. Clarence Lucien McClellan, Kerrville, Texas, died September 15, 1955, at the Veterans Administration Hospital in Legion.



DR. C. L. MCCLELLAN

Dr. McClellan was born in Hinds County, Miss., on June 11, 1874, of William Alexander and Missouri Ann McClellan. His parents moved to Texas when he was 3 years old, and he was educated in the public schools of Erath County. In 1901, he entered the first class of the University of Dallas Medical Department, which later became the Baylor University College of Medicine. Dr. McClellan received his doctor of medicine degree from the Physicians and Surgeons College, St. Louis, in 1905, after which he spent three years in Mexico. When he returned to the United States, he spent several years practicing in Rockport, Aransas Pass, Groom, Odessa, and De Leon, then moved to New Mexico where he practiced for a short time before entering the Army Medical Corps in 1917. He served during World War I as a first lieutenant at Camp Travis, San Antonio. He also was a veteran of the Spanish American War.

In 1918, Dr. McClellan returned to Clovis, N. Mex., where he served as county health officer and president of his county medical society. He was a charter member and post commander of the American Legion there, and for a time directed the local Veterans Administration work.

Returning to Texas in 1923, Dr. McClellan practiced one year in San Antonio, and studied two years in New York, where he specialized in diseases of the eye, ear, nose, and throat. He then returned to practice in San Antonio until his health failed in 1929, at which time he entered the Veterans Administration Hospital at Legion. Since then, he had been in and out of the hospital, and at various times he did private practice in Kerrville and supervised the eye, ear, nose, and throat division of the hospital.

He was elected to honorary membership in the Texas Medical Association in 1949, after having been a member throughout most of his professional career in Texas through the Nueces, Potter, Bexar, or Kerr-Kendall-Gillespie-Bandera Counties Medical Societies. He was president of the latter group in 1933. He also was an honorary member of the Southern Medical Association and the Texas Society of Ophthalmology and Otolaryngology, and was a member of the American Medical Association and the Fifty Year Club. Dr. McClellan was a thirty-second degree Mason and a member of the Shrine and the Methodist Church.

He was married in 1906 to Miss Alma Shannon of De Leon. Survivors include Mrs. McClellan; a daughter, Mrs. A. P. Allison; and three grandchildren, all of Kerrville.

DR. BEN E. HUDGINS

Dr. Benjamin Ellis Hudgins, honorary member of the Texas Medical Association, died in a Dallas, Texas, hospital November 30, 1955, of bronchopneumonia following a cerebral vascular accident. He had suffered two previous attacks.

DR. BEN E. HUDGINS

Dr. Hudgins was born March 25, 1873, in Scottsboro, Ala., and was the son of A. Pierce and Eliza Jane (Skelton) Hudgins. He attended public schools in Henrietta, Texas, and attended the Fort Worth Medical College in 1898. He then entered the Memphis, Tenn., Hospital Medical College, from which he was graduated in 1901. He took post-

graduate work in New Orleans the following year. Dr. Hudgins began his medical practice in Crandall, and moved in 1906 to Mesquite, where he practiced for 12 years. In 1918 he moved to Dallas, where he was in private practice until 1934. At that time, he became superintendent and physician in charge of the Dallas city-county convalescent home and hospital, a position which he held until 1951, when illness forced him to retire.

Dr. Hudgins had been a member of the Texas Medical Association through the Kaufman or Dallas Counties Medical Societies almost continuously since 1904, and was elected to honorary membership in 1952. He also belonged to the Fourteenth District Medical Society. In 1953 he received a Golden T certificate from the University of Tennessee College of Medicine, with which the Memphis Hospital Medical College had combined, in recognition of his 50 years of service as a physician.

During World War II, Dr. Hudgins received a citation from President Roosevelt for his contributions toward the physical examination of recruits.

He was a Scottish Rite Mason and a past steward of the Grace Methodist Church.

Survivors include Mrs. Hudgins; two daughters, Miss Grace M. Hudgins and Mrs. Cecil P. Craddock, both of Dallas; one son, David N. Hudgins; and two grandchildren, David Ellis and Emily Anne Hudgins, Healdsburg, Calif. A brother, Dr. D. H. Hudgins, Forney, died in July, 1955.

DR. W. W. FLOWERS

Dr. William W. Flowers, Livingston, Texas, died September 23, 1955, of congestive heart failure.

He was born January 27, 1897, in Dyer County, Tenn. He received his preliminary education at the University of

DR. W. W. FLOWERS

Kentucky and the University of Tennessee, and was graduated from Tulane University School of Medicine in 1924. He interned at the Illinois Central Hospital, New Orleans. Dr. Flowers began his medical practice in Livingston in 1926, and was in active practice there at the time of his death.

He was a member of the Polk-San Jacinto Counties Medical Society, and served as its secretary in 1944. He also was a member of the Ninth District Medical Society, the Texas Medical Association, the Masonic Lodge, the American Legion, and the Livingston volunteer fire department. He was active in Boy Scout work, and was a captain in the Texas National Guard.

Survivors include Mrs. Flowers; one step daughter, Mrs. Gloria Galloway, Beaumont; and four sisters, Miss Lillie Flowers, Halls, Tenn.; Mrs. J. Sorrell and Mrs. Travis Roberson, both of Sorrels Chapel, Tenn.; and Mrs. Maggie Clark, Bonicord, Tenn.

DR. W. L. ASKEW

Dr. Wesley Lafayette Askew died November 23, 1955, at a hospital in Amarillo, Texas, of acute myocardial infarction.

He was born September 22, 1893, in Marble Falls, and was the son of Mary Caroline (Kinser) Askew and A. L. Askew. He attended high school in Marble Falls, and was graduated in 1916 from Vanderbilt University School of

DR. W. L. ASKEW

Medicine, Nashville, Tenn. He interned at the City Hospital, St. Louis, in 1916 and 1917, then served two years in the Army Medical Corps as a first lieutenant at Fort Sam Houston, San Antonio. He began his medical practice in Amarillo, where he remained throughout his professional career.

Dr. Askew was a member of the Texas Medical Association, the American Medical Association, the Potter County Medical Society, and the Third District Medical Society. He also was a member of the Methodist Church and was a charter member of the Amarillo Masonic Lodge. One of Dr. Askew's special interests was raising Hereford cattle.

In 1919, Dr. Askew and Miss Margaret Hatcher were married in San Antonio. Mrs. Askew survives, as do a son, Dr. W. L. Askew, Jr., who is completing his medical training at Vanderbilt University School of Medicine; and three brothers, W. A. Askew, Sr., Amarillo; George Askew, and John Askew, both of Marble Falls.

DR. C. C. COOKE

Dr. Charles Christopher Cooke, Cleburne, Texas, died October 16, 1955, in the Veterans Administration Hospital in Lisbon after a lengthy illness.

Dr. Cooke was born June 3, 1878, in Carroll County, Tenn., and received his preliminary education there. His parents were George M. and Sophia Virginia (Blair) Cooke. Dr. Cooke and Miss Emma E. Johnston were married in Tennessee in 1898, and came to Texas in a covered wagon the next year. Dr. Cooke farmed and taught school several years to pay for his medical education. During that time, they lived briefly in Ellis and Hill Counties, then settled

DR. C. C. COOKE

near Keene in Johnson County. Dr. Cooke did premedical work at the Keene Academy, then enrolled in the University of Texas Medical Branch, Galveston, from which he was graduated in 1907. He then began his practice in Johnson County, and in 1910 he went to California to be an instructor at Loma Linda College. He soon returned to Keene, where he operated a sanitarium for about two years. In 1912, he helped build the Cleburne Sanitarium, which he operated until 1917. At the outbreak of World War I, Dr. Cooke was one of the first Texas physicians to volunteer for service in the Army Medical Corps. He served as a captain in Fort Sam Houston, San Antonio; Camp Cody, Cody, Wyo.; Hoboken, N. J.; Camp Merritt, N. J.; London, England; and Brest, France.

When he returned in 1919 to Cleburne, he and Dr. B. H. Turner bought the old Clebarro College and converted it into the Meadowlawn Sanitarium, which Dr. Cooke operated until ill health forced him to retire in 1950. Two years later, he donated the land on which the sanitarium stood to the Cleburne Public School system, and the C. C. Cooke elementary school was erected there. In April, 1955, a resolution in honor of Dr. Cooke's service to his community was adopted by the Texas House of Representatives.

Dr. Cooke had been a member of the Texas Medical Association through the Johnson County Medical Society almost continuously since 1908. He took an interest in church and community affairs, and owned considerable land in Johnson County.

Dr. Cooke is survived by Mrs. Cooke; three sons, Carroll C. Cooke, Charles C. Cooke, and George Cooke; and two daughters, Mrs. Juanita Cooke Hague and Mrs. Esther A. Anderson, all of Cleburne.

DR. W. E. CHILTON

Dr. William Ernest Chilton died at his home in Fort Worth, Texas, October 27, 1955, of monocytic leukemia.

The son of James William and Mary Elizabeth (Hatcher) Chilton, Dr. Chilton was a native of Comanche, born May 5, 1877. He received his academic degree from Bethel College, Russelville, Ky.; attended Tulane University Medical Department, New Orleans; and was graduated from the old Fort Worth University Medical Department in 1900. He was in practice in Fort Worth until his retirement in 1946, teaching gynecology at his alma mater for a time. His civilian career was interrupted by two years of service during World War I as a captain in the Army Medical Corps in command of hospital trains carrying wounded soldiers from ports of debarkation to hospitals and rest camps throughout the nation.

Dr. Chilton was a member continuously for more than fifty years of the Tarrant County Medical Society, Texas Medical Association, and American Medical Association. He was elected to honorary membership in the state organization in 1949. He was a fellow of the American College of Surgeons and on the staff of City-County (now Peter Smith) Hospital. He was a Scottish Rite Mason and Shriner and a member of Kappa Sigma, Phi Delta Phi, Fort Worth Chamber of Commerce, Fort Worth Club, and River Crest Country Club.

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Mrs. Chilton, the former Miss Mabel Clare Long, whom Dr. Chilton married in 1914, died in 1951. A son, Major A. L. Chilton, was killed over Germany in World War II while serving as a fighter pilot in the Army Air Force. Surviving the doctor are a son, W. E. Chilton, Jr., and a daughter, Mrs. J. O. Phillips, both of Fort Worth; a sister, Mrs. P. V. Montgomery, Dallas; and five grandchildren.